

## Automatic Draft of Monthly Premiums

I authorize Delta Dental of Virginia to deduct monthly premium payments from the account identified below
Bank Name
Bank Address
City, State, ZIP Code
Account Number
Transit/ABA Number
The debit entry will be initiated the on the first business day of the month for the current month's premium. This authorization will remain in effect until Delta Dental of Virginia receives written notification to terminate monthly payments by bank draft. The written notification must be received by Delta Dental of Virginia thirty (30) days prior to the monthly draft discontinuation effective date.
Company Name
Address
City, State, ZIP Code
Phone Number
Group Number
Authorized Signature
Date
PLEASE ATTACH A VOIDED CHECK HERE



## Instructions for Automatic Draft of Monthly Payments

In order to participate in the automatic draft program, an authorization form <u>must</u> be signed allowing Delta Dental of Virginia to draft your company's account. Please complete and submit the attached form, along with a voided check, to Delta Dental via fax or email to:

Fax: 540-776-8109

Email: billing@deltadentalva.com

If you do not have access to fax or email, please mail the form to the following address:

Delta Dental of Virginia Attention: Billing and Eligibility Department 4818 Starkey Road Roanoke, VA 24018

The debit to your company's account will occur on the first business day of the month for the current month's premium. Once the authorization form is received and your account is set up, the first draft may be a test of the account information. Delta Dental will contact you if we cannot successfully execute this process.

If you provide a Company ID to the Financial Institution that you utilize in order for drafts to be completed, please note that the Company ID for Delta Dental of Virginia is 4540844477.

Please contact the Billing and Eligibility Department at 800-237-6060 if you have any questions.