

Authorization Agreement for Automatic Payments

Company Name _____ Plan Number _____
Address _____
City _____ State _____ Zip Code _____
Telephone _____ Email Address _____

PLEASE ATTACH A COPY OF A VOIDED BLANK CHECK
(REQUIRED FOR PROCESSING)

As a convenience to me, I hereby authorize Washington Dental Service to initiate entries to my bank account for monthly dental premiums. I understand this will occur each month and that a record of the transaction will appear on my monthly bank statement. I agree that each payment shall be the same as if it were an instrument personally signed by me. This authorization will remain in effect until revoked by me in writing to Washington Dental Service. In addition, I have the right to stop payment of a charge by timely notification to my financial institution prior to my account being charged. I understand, however, that both my financial institution and Washington Dental Service reserve the right to terminate this payment plan (or my participation therein). By signing below, I agree to the follow terms:

- 1) I understand that payments will be withdrawn from my account by the first of each month and will be posted within five business days. Washington Dental Service will need to receive any banking changes by the **15th** of the month prior to the withdrawal date. All bank change information received after the **15th** will be effective for the following month premiums.
- 2) Washington Dental Service may post insurance rate increases to my account without requiring additional authorization.
- 3) Payments that are not honored will not be submitted a second time by Washington Dental Service.
- 4) Washington Dental Service will send notices of payments that are not honored by your bank.
- 5) If a payment is not honored, my insurance coverage will be terminated 15 days after the notice has been sent, retroactive to the last date of fully paid coverage.
- 6) If I wish to continue your insurance coverage after a payment is not honored, Washington Dental Service must receive full payment with 10 days.
- 7) Reinstatement is possible only if payment is received within 30 days of the notification regarding the not-honored payment. Beyond the 30 day period reinstatement will not be possible.
- 8) After two non honored consecutive payments, reinstatement will not be possible.

Authorized Individual of the Account _____	
Signature _____	Date _____
Print Name _____	Title _____
Bank Name _____	
Bank Address _____	
Name(s) on Bank Account _____	
Bank Account Number _____	Routing Number _____
Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	

Please return signed authorization and a copy of a VOIDED CHECK (deposit slips are not acceptable) to:

Washington Dental Service
PO Box 75983
Seattle, WA 98115-0983
800-572-7835

Automated Clearing House Payment Instructions

Washington Dental Service now offers you the convenience of paying your dental premium electronically through an automated clearing house (ACH) program. This program helps reduce the amount of time spend paying bills and ensures that your premiums are paid timely every month.

To enroll in the ACH program, simply complete and sign the attached authorization agreement form and return in to Washington Dental Service along with a copy of a voided check. Please note that you must include a voided check and not a deposit slip.

For existing plans, the process may take more than one billing cycle, depending on when the authorization forms are received.

In the event there are not enough funds in your account to cover the premium payment, we will require that payment be received prior to the end of the month to maintain your coverage, along with a \$25.00 nonsufficient funds fee.

Once we receive payment, Washington Dental Service will continue with the ACH withdrawal for the following month.

If you have any questions about this process, please feel free to contact your insurance representative or Washington Dental Service at (800) 572-7835, ext 2392.