

Automatic Payment: A Convenient Way to Pay

To begin saving valuable time and money, enroll in Delta Dental of Rhode Island’s automatic payment program – an easy-to-use debit feature that conveniently deducts pre-authorized premium payments from your bank account each month.

Advantages of Auto Pay

Sign up now to begin enjoying the advantages of auto payment, including:

- Eliminates late payments, ensuring there are no lapses in coverage
- Saves you money by reducing postage and check writing fees
- Saves you time – auto payment is fast, easy and convenient.

While premiums are due on the first of the month, the bank account will not be debited until the first Tuesday of each month. Your monthly invoice will indicate the exact date and amount of the automatic payment, making it easy for you to keep track of your premium payments.

Account and Billing Information

To sign up for the automatic payment option, complete this form, attach a copy of a canceled or voided check showing the bank account to be debited and return them to Delta Dental with your next premium payment. Remember to include the group and sublocation numbers (eight digits) that you wish to pay with the automatic payment option. For assistance in filling out this form, or to update banking information, please contact the Billing department at (401) 752-6200 or toll free at (800) 598-6684. Send your completed form to: Delta Dental of Rhode Island, P.O. Box 1176, Providence, RI 02901.

Account Information (Please Print)

Name on Checking Account _____ Transfer Effective Date _____

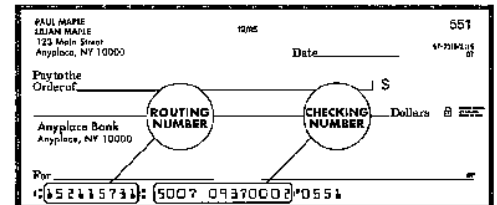
Group Name _____ Group/Sublocation No. (eight digits) _____

Bank Information (Please Print)

Bank Name _____ Bank Phone Number _____

Bank Street Address _____ City, State and Zip Code _____

Account Number _____ Routing Transit Number (see sample check) _____



Please use this sample check as a guide to find the bank’s routing number and checking account number.

Authorization

I hereby authorize Delta Dental of Rhode Island to withdraw funds from the above referenced checking account on the first Tuesday of each month for payment of dental insurance premium(s). I understand that if funds are not available, coverage will be subject to termination after appropriate notification and that the account holder will reimburse Delta Dental of Rhode Island for any expenses incurred as a result of insufficient funds.

Printed Name and Title (Required) _____

Authorized Signature (Required) _____ Date _____

Note: To cancel automatic payment withdrawal, Delta Dental of Rhode Island requires 30 days prior written notice.