

# Automatic Draft of Monthly Premiums

I authorize Delta Dental of Virginia to deduct monthly premium payments from the account below.

Bank name \_\_\_\_\_

Bank address \_\_\_\_\_

City, State, ZIP code \_\_\_\_\_

Account number \_\_\_\_\_

Transit/ABA number \_\_\_\_\_

The debit entry will be initiated 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. 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 \_\_\_\_\_

ATTACH A VOIDED CHECK HERE

## Instructions for Automatic Draft

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

Fax: 540-776-8109

Email: [billing@deltadentalva.com](mailto:billing@deltadentalva.com)

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

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

The debit entry will be initiated 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 your financial institution for drafts to be completed, **note that the Company ID for Delta Dental of Virginia is 4540844477.**

*Contact Billing and Eligibility at 800-237-6060 if you have questions.*