

Bank Draft Authorization

Please complete this section to initiate monthly deduction from your bank account.

Bank Name _____ Checking Account Savings Account

Routing # (Transit/ABA No.) _____ Account # _____

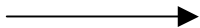
ACH Debits: Employers Dental Services
ID Number: 1860328922

I (we) hereby authorize Employers Dental Services, hereinafter called COMPANY, to initiate debit entries to my (our) bank account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

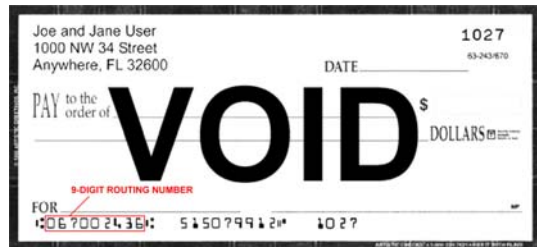
This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) has the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by DEPOSITORY, provided I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first. All deduction will be made from your savings or checking account between the 13th and the 20th of each month. A return item charge will be assessed if an automatic deduction is returned unpaid; the amount of the charge will be at the rate in effect at the time the item is returned to EDS.

Signature **X** _____ Date _____

**Please write VOID on a blank
check and attach here.
(See Example)**



Example



Deadline: Coverage is effective on the first of the current month, when application and payment are received on or before the 10th.

For assistance call Customer Service at 1-800-722-9772

