

ACH Pre-Authorized Payments Agreement

This is my authorization to NCAR Dental Plan,

To automatically debit my _____ checking _____ savings account _____
Number

_____ at _____ in
Bank Transit/ABA No. Financial Institution

_____, _____
City State

I understand that this authorization will be in effect until I notify my financial institution in writing that I no longer desire this service, allowing it reasonable time to act on my notification. I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account.

I have the right to stop payment of a debit entry by notifying my financial institution before the account is charged. If an erroneous debit entry is charged against my account, I have the right to have the amount of the entry credited to my account by my financial institution, if, within 15 days following the date on which I was sent a statement of account or a written notice of such entry or 45 days after posting, whichever occurs first, I give my financial institution a written notice identifying the entry, stating that it is in error and requesting credit back to my account.

This authorization is non-negotiable and non-transferable.

Customer Name (please print)

Social Security #

Signature

Date

Phone Number

Email Address

PLEASE ATTACH A VOIDED CHECK

PLEASE NOTE: Your dental coverage under the NCAR dental program shall terminate without prior notice upon failure to make required payments of premiums (whether they be monthly, quarterly, semi annually or annually) within 30 days of the due date.

Please remember to notify us if your mailing address or other contact information changes.