

# Authorization agreement for autopay (EFT)



Delta Dental of Oregon & Alaska

## Section 1 > Transaction type

- New setup                       Change financial institution  
 Change account number       Change account type

## Section 2 > Initial payment information

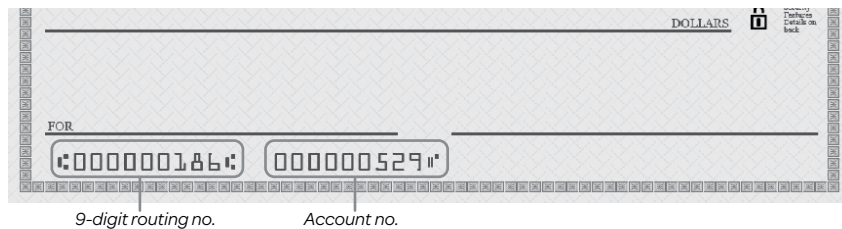
- A. Complete and sign below as account holder for automatic bank deduction of premium.  
 B. Attach a copy of your voided check from the account to be drafted.

Applicant	Account holder
Bank name	
Account no.	Routing no.

## Section 3 > Recurring payment information

- Draft monthly recurring payment from:  
 Same bank    Different bank (*indicated below*)

Account holder	Bank name
Bank routing no.	Account no.



## Section 4 > Authorization

I authorize Moda Health to charge my (individual or joint) checking account for monthly health premium for the above individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account is charged.

Authorizing payment does not guarantee coverage. The first monthly premium amount will not be debited from your account until your application for individual health plan coverage has been approved by Moda Health Underwriting. You will be notified in writing of your application status no later than 60 days from receipt. If your application is approved, the coverage effective date will be the first day of the month following approval. If your application is not approved, you will be notified in writing, and your account will not be debited.

Signature X	Signature date
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**Ready to submit?** Mail or fax this form with a copy of a voided check to Moda Health:  
**Mail:** Moda Health, Attn: Billing and Eligibility, 601 S.W. Second Ave., Portland, OR 97204-3156  
**Fax:** 503-219-3696 Attn: Billing & Eligibility Individual

**Questions?** Contact Moda Health Customer Service at 888-217-2365. (TTY users, dial 711.)

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