Delta Dental Individual and Family Dental Plan

ACH Withdrawal Questions and Answers

Please see page 2 of this document for the ACH Authorization Form

Q. **How do I set up an ACH withdrawal for my portion of the monthly premium?**

A. Complete the *ACH Withdrawal Authorization Form*. To withdraw from a checking account, attach a voided check to the form. To withdraw from a savings account, provide the requested information (it is recommended that you obtain a letter from your bank identifying the account and transit/routing number for your bank). **Mail to:** ACH Withdrawal, Delta Dental, c/o Crosby Benefit Systems Inc., PO Box 981400, Boston, MA 02298-1400.

Q. **Can I attach a cancelled check instead of a voided check?**

A. No. You must attach a voided check not a cancelled check. If you attach a cancelled check, you may be at risk of the bank negotiating your check again.

Q. **Can I fax the authorization form to Crosby?**

A. Yes, you may fax the form and copy of your voided check to Crosby at 617-928-0001.

Q. **What happens if I do not complete the authorization form correctly or do not include the proper documentation?**

A. We will contact you if your form is not completed correctly or if additional documentation is required. You will continue to pay your premium with a "live" check until the ACH has been set up.

Q. **Can I make my initial payment by ACH?**

A. No. You must make your initial payment by check or money order. Subsequent payments will be withdrawn on the 20th of the month (or next business day) prior to coverage.

Q. **How do I know when my ACH payment will begin?**

A. If you are currently paying by check and would like to change to ACH (automatic withdrawal from your bank account), please allow time for Crosby to process this request. Requests received by the 10th of the month will be processed for the following month's premium payment. Requests received after the 10th of the month, or those with an issue related to the information provided, will not be processed in time for the following month's payment. For example:

- ACH Request Forms received on or before May 10th will be processed for June's payment.

- ACH Request Forms received on May 11th or after, will be processed for July's payment.

To ensure your payments remain up-to-date, please check your bank account activity to confirm that your first ACH withdrawal occurred as expected. If necessary, please continue payments by check as appropriate until your ACH can be processed. If you have any questions, please call Crosby Benefit Systems at 800-462-2235.

Q. **When will the premium be withdrawn from my account?**

A. The payment of your premium will be withdrawn two business days before the 20th of each month.

Q. **How do I stop ACH transfers? What if I close or change my account?**

A. To stop transfers, you must notify Crosby in writing. Please allow at least two weeks to process this request. Please provide the date on which this request is to be effective. Crosby will remove you from the ACH transfer system and you must begin paying premiums by mailing a check. If you would like to request premium payment coupons, contact us 800-462-2235.

ACH Withdrawal Authorization

For Delta Dental Individual and Family Dental Plan Premium Payments Only

This option is available for those sending payments to: PO Box 981400, Boston, MA 02298-1400

Agreement Type	___ New Agreement ___ Change Account *(please choose one)*
Employee Information ***Please Print***	Name on Bank Account ______________________________ Last 4 Soc Sec # XXX-XX-________ Participant Name __________________________________ Insurance: **Delta Dental Individual & Family Dental Insurance** Home Address ____ Daytime Phone No. (______)_______________ Email address ___________________________
Account Information	I authorize Crosby Benefit Systems to withdraw my portion of the monthly premium from my: ___**CHECKING** account or ___**SAVINGS** account
Please SIGN	**Signed** _______________________________________ **Date** _________________
Complete for Checking Account Only	**Please tape a voided check for checking account. (Do not staple.)** **DO NOT USE A CANCELLED CHECK.** John Doe 1245 1000 Main St. Date:____________ Anytown, USA 11111 V - O - I - D Pay to the Order Of: ______________________________ $_____________ **PLEASE TAPE A VOIDED CHECK HERE** Memo________________ ________________________ | 123456789	00111 11111	1245
Complete for Savings Account	For Savings Account: Routing/Transit Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ Savings Account Number: __________________________________ *Or attach a bank letter with savings routing and account number*
Submission Information	**Fax completed forms to:** 617-928-0001 **Or mail to:** ACH Withdrawal Delta Dental c/o Crosby Benefit Systems, Inc. PO Box 981400 Boston, MA 02298-1400
Withdrawal Timing	Requests received by the 10th of the month will be processed for the following month's premium payment. Requests received after the 10th of the month, or those with an issue related to the information provided, will not be processed in time for the following month's payment.
Cancellation Information	To stop transfers, you must notify Crosby in writing at least two weeks prior to the 5th of the month in which you wish to stop the ACH withdrawal. Please provide the date on which this request is to be effective. Crosby will remove you from the ACH transfer system and you must begin paying premiums by mailing a check. If you would like to request premium payment coupons, contact us at 800-462-2235.
For Admin Use Only	Set Up (name) _____________ Date Received ___/____/____ Date Set Up _____/_____/_____Paid Thru Date___/___/___ Contacted Participant Y N Amount due: $ Missing Information________________________