PAYMENT AUTHORIZATION FORM

GROUP NAME:

Monthly Premium: Dental $_____+ Vision $_____= Total Monthly Premium $_____

Method of Payment (Select One)

CHECKING ACCOUNT (ACH)

☐ **Monthly Bank Account Debit**
*Please submit a voided check

_____
Bank Name

_____
Routing Number

_____
Account Number

CREDIT CARD

☐ **Monthly Credit Card**
*Please provide your credit card information below:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

_____
Name on Card

_____
Credit Card Number

_____ _____
EXP CCV Code

AUTHORIZATION AGREEMENT

I authorize Argus Dental & Vision, Inc. to initiate electronic debits to the account listed above for payment of my insurance premium. I certify that I am an authorized user on the above listed account. I acknowledge that debits to my account for premium due will occur on a regular recurring basis based on the payment frequency indicated above until such time as coverage terminates or until I notify Argus Dental & Vision to terminate these transactions.

I understand that it may take up to two weeks to process a request to discontinue recurring payments. In order to make changes to this authorization (such as change in bank account, method of payment, or termination of payment) I must provide Argus Dental & Vision at least two weeks' notice in advance of the next scheduled payment date.

Based upon my authorization Argus Dental & Vision will debit my account for any current and outstanding due premiums on the 20th of each month for the following month's premium. Premiums are due on the 1st of each month. For initial payments I acknowledge that Argus Dental & Vision may debit my account upon acceptance and approval of my application.

If any authorized payment is returned or dishonored by my bank, I acknowledge that I am responsible for any fees my bank may charge. I understand also that I may incur a return payment fee of $25 charged by Argus Dental & Vision if the return is due to insufficient funds. I acknowledge that such a fee, if charged, may be automatically debited from my authorized account on the next payment date. I am responsible for remitting payment within the policy grace period. If payment is not received by Argus Dental & Vision within the defined grace period I acknowledge that my coverage may be cancelled in accordance with the terms of the insurance contract.

I acknowledge that the origination of these electronic transactions (ACH and Card) must comply with applicable provisions of US Law.

Printed Name _____

Signature _____ **Date** _____