Individual Plan Auto Pay Form

Please complete this form if you would like to pay your individual dental plan premiums via Auto Pay (monthly recurring checking account deduction or credit care charge). Please send via fax or mail to:

Willamette Dental, ATTN: Insurance Department
6950 NE Campus Way, Hillsboro, OR 97124
Fax: 503.952.2679

Policyholder Name (Last, First, MI):	
Policyholder date of birth:	
Certificate number (if known):	

1. I would like to…

☐	**Setup a new auto pay** (Complete the information below)
☐	**Change my auto pay** (Complete the information below)
	Month for auto pay to start:

For checking account deduction

Bank name:
Bank (ABA) routing number:
Checking account number:

For recurring credit card charges

Card type ❑ Visa ❑ MasterCard ❑ Discover		
Credit card number		
Expiration date		3-Digit security code
Billing address		
City	State	Zip

I hereby authorize recurring monthly deductions for the then-current premium amount from my checking account/credit card for the above named Policyholder and any enrolled dependents. I understand deductions will occur between the 5th and 7th day of each month. This authorization will remain in effect until I have provided 5 business days' prior written notice to Willamette Dental and my bank.

2. Signature authorization

Policyholder's signature _____ Date signed _____

Policyholder printed name _____