DELTA DENTAL®

TRICARE® Retiree Dental Program

Recurring Credit Card Payment Authorization Form

Enrollees in the TRICARE Retiree Dental Program (TRDP) who cannot pay their monthly premiums through government-mandated retired pay allotment or who are unable to establish an alternate electronic funds transfer (EFT) method to pay their monthly premiums may schedule their premium payments to be charged automatically to their credit card. By completing the information below and signing this form, you are authorizing regularly scheduled charges to your Visa®, MasterCard® or Discover® card. Here is how it works:

- Each billing period, you will be charged the total amount of your premium due for that period, not to exceed your current monthly premium amount.
- The premium charges will appear on your credit card statement.
- If your recurring credit card payment is rejected, your premium payment will be considered past due. You will be notified of your options for paying the past-due amount separately from your monthly recurring credit card charge in order to bring your account to a current status. Failure to bring your account current could result in termination of your enrollment in the TRDP.

Mail this completed and signed form to: Delta Dental of California, Federal Government Programs, PO Box 537008, Sacramento, CA 95853-7008. You may also fax the form to 916-851-1559.

Please complete the required information below:

I, _____ authorize Delta Dental to charge my credit card indicated below on the fifth day of
(subscriber's full name)

of each month for payment of my TRDP monthly premium. I understand that my account will be charged up to, but not more than, the premium payment amount due for the current billing period.

Credit Card Type: ☐Visa® ☐ MasterCard® ☐ Discover®

Credit Card Number _____

Expiration Date _____ CVV (3-digit number on back of Visa®/MasterCard®) _____

Cardholder Name (as it appears on credit card) _____

Cardholder Billing Address _____ Phone _____

City, State, ZIP_____ Email _____

I authorize Delta Dental to charge the credit card indicated on this authorization form according to the terms outlined above. If the above-noted payment date falls on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Delta Dental in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This authorization is for payment of my premiums as indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

SUBSCRIBER SIGNATURE _____ DATE _____

SUBSCRIBER IDENTIFICATION NUMBER_____