



## Colorado Dental Association Benefit Plan Authorization Agreement for Electronic Payment — Individuals —

This Authorization Agreement for Pre-Arranged Payments (the "Agreement") is entered into effective \_\_\_\_\_, 200\_\_.

Participant Name: \_\_\_\_\_ ("Participant")

Participant's Bank Name: \_\_\_\_\_ ("Bank")

Participant's Bank Account Name: \_\_\_\_\_ ("Bank Account")

Participant's Bank Account Number: \_\_\_\_\_

Bank's Routing Number (See sample attached): \_\_\_\_\_

Checking Account

Savings Account

I hereby authorize Colorado Dental Association Benefit Plan, Inc. or CNIC Health Solutions, Inc. to effect payment of any amounts owed by Participant to the Colorado Dental Association Benefit Plan, Inc. as amounts become due by initiating debit entries to Participant's account at the Bank indicated above. I hereby authorize and request Bank to accept any debit entries initiated by Colorado Dental Association Benefit Plan, Inc. or CNIC Health Solutions, Inc. and to debit the same to Participant's account without liability to the Bank for the correctness of the entries.

It is understood and agreed that I may terminate this Agreement at any time upon ten (10) business days prior written notice to CNIC Health Solutions, Colorado Dental Association Benefit Plan, Inc. or Bank.

I understand that notification of insufficient funds ("NSF") or closed account will generate an additional \$30.00 NSF charge to Participant. I understand that each month's premium payment is generally debited to Participant's Bank Account on the twentieth calendar day of each month, or the next business day, if the twentieth falls on a weekend or bank holiday. I understand that Participant must submit payment within ten calendar days (via cashier's check or money order) for any amounts that become overdue due to an insufficient funds notification or closed bank account, unless other payment arrangements are authorized in writing by CNIC Health Solutions, Inc. or Colorado Dental Association Benefit Plan, Inc.

I understand that I must **attach a voided check** for the Bank Account to this completed form.

If an erroneous debit is made to Participant's account, I authorize CNIC Health Solutions, Inc. or Colorado Dental Association Benefit Plan, Inc. and Bank to stop payment, reverse the entry or make any adjustments necessary to Participant's account to correct the erroneous entry.

CNIC Health Solutions, Inc. or Colorado Dental Association Benefit Plan, Inc. shall, within not less than five (5) calendar days before such entry is to be first debited to Participant's account, provide Participant with written notification of the amount of such entry via the initial enrollment package and/or written notification. CNIC Health Solutions, Inc. or Colorado Dental Association Benefit Plan, Inc. shall, within not less than five (5) calendar days before any entry to be debited to Participant's account that reflects any subsequent rate increase(s), provide Participant with notification of the amount of such entry.

Participant (Print Name): \_\_\_\_\_

Authorization Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Second Account Authorizer (if required): \_\_\_\_\_

Second Authorization Signature (if required): \_\_\_\_\_ Date: \_\_\_\_\_

Colorado Dental Association Benefit Plan  
Authorization Agreement for Electronic Payment  
— Individuals —

Sample Check Information:

John Doe  
123 Shady Lane  
Yourtown, AA 12345

DATE \_\_\_\_\_

2048

FW TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_

void

Your Savings & Loan  
Cleveland, OH

⑆ 241022233 ⑆ 333962222 ⑆ 2048

**241022233**  
**Routing Number**

**333962222**  
**Account Number**

**Staple a Voided Check From Participant's Bank Account Here:**

(NOTE: Do NOT attach a blank deposit slip. Deposit slips do not have the required bank account information.)