Authorization Agreement For Automatic Monthly Bank Draft

Name(s)	Social Security Number										Checking ☐ Savings ☐

I (we) hereby authorize Union Security Insurance Company to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such account.

Bank Name	City	State

Include your Checking or Savings Account Number in the boxes below:

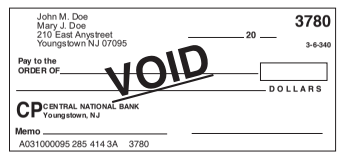
Account Number																

IMPORTANT

If you selected the Monthly Bank Draft Payment method, enclose a voided check, your first month's prepayment fee and $35 enrollment fee with this form and send them to us.

This dental plan is provided by Union Security DentalCare of Georgia, Inc. and administered by Union Security Insurance Company. This is not an insurance plan.

Prepayment fees are deducted from your authorized account on the 15th of the month prior to the month of benefits. Plan automatically renews after 12 months.



This authorization is to remain in full force and effective until Union Security Insurance Company has received WRITTEN notification from me (or either of us) of its termination by the 10th of the month prior to the month when the enrollment is to be terminated.

Signature_____ **Date**_____

Union Security DentalCare of Georgia, Inc. Application Form

Select Individual Prepaid Dental Plan

REP NUMBER

Your Social Security Number	Last Name	First Name	Middle I.	Sex M ☐ F ☐

IMPORTANT
Write the Dental Facility ID Number of the dentist(s) you choose from the directory in the space(s) below.

Your Date of Birth / /	Address		
Home Phone ( )	City	State	Zip Code+4

List Dependents to be Enrolled First Name Middle I. Last Name (if different)	Relationship	Date of Birth	Sex	Dental Facility Number
Spouse		/ /	M ☐ F ☐	
Child		/ /	M ☐ F ☐	
Child Attach a separate sheet of paper for additional children.		/ /	M ☐ F ☐	

Prepayment Fee Amount $_____
+Enrollment Fee $ 35.00
Total Enclosed $_____

Select Payment Choice

☐ **Annual Payment -** make the check payable to Union Security Insurance Company.
☐ **Charge my annual prepayment fees**
☐ **Automatic Monthly Bank Draft -** complete the Authorization Agreement

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
Mo._____ Yr._____

By my signature below, I understand that this Individual Prepaid Dental Plan is a non-refundable one (1) year program. I also understand that a full description of plans will be provided in the Individual Prepaid Dental Plan Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to Union Security Insurance Company my dental records, photocopies or information regarding such procedures to the extent permitted by law.

Agent's Signature _____ **Date**_____ **Subscriber's Signature**_____ **Date**_____

11.60 18.63 28.37
127.20 211.56 328.44
KC4173AGA-E

Please retain a copy of this application for your records. This is an important document that will become part of your contract.