DMBA

AUTOMATIC PREMIUM DEBIT AUTHORIZATION AGREEMENT

PERSONAL INFORMATION (REQUIRED)

Account holder name (print as it appears on the account): _____

DMBA ID number: _____ Social Security number: _____

ACCOUNT HOLDER AUTHORIZATION

I hereby authorize DMBA to initiate debits for the monthly premium amount to the financial institution and account indicated below. I understand that:

- If DMBA receives this completed form by the 10th of the month, automatic payments will begin the following month.
- If DMBA does not receive this form by the 10th of the month and I have not paid by personal check, I will have a double deduction taken from my account the following month.
- Payments will be deducted from my account on the 15th business day of each month.
- If funds are not in my account for the monthly premium, my coverage will be in jeopardy of termination.
- This authorization will remain in effect until canceled by me or the financial institution identified with the account or until coverage is terminated.
- I may end this agreement at any time by notifying DMBA in writing, allowing DMBA reasonable time to act upon my notification.

Account holder signature: _____ Date: _____

ACCOUNT INFORMATION

ATTACH YOUR VOIDED CHECK HERE

(DO NOT USE A DEPOSIT SLIP)

Institution name: _____ Institution routing number: _____

Account number: _____ Account type (check one): ☐ Checking ☐ Savings

Institution street address: _____

City:_____ State:_____ ZIP code:_____ Phone number:_____

Please return this completed form to retirementhelp@dmba.com. You may also mail it to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.