

TRICARE DENTAL PROGRAM
Credit Card/Electronic Funds Transfer (EFT) Authorization



SECTION I NOTE: Incomplete information will delay your authorization.

Sponsor Name – Last Name _____ MI _____ First Name _____
Sponsor Social Security Number or DBN _____ Date of Birth (mm/dd/yy) _____ Gender M F
Home Address _____ City _____ State _____ Zip Code _____
Country _____ Home Phone _____ E-mail Address _____
Please identify contract(s) affected by this authorization: Sponsor Family

SECTION II

Visa® MasterCard® American Express Discover
Credit Card Number _____ Expiration Date (mm/yy) _____ Security Code _____
➤ Authorized Signature _____ Name of card holder as it appears on credit card _____
 Electronic Funds Transfer (EFT) Please check Checking Savings (please see below for further instruction)
Date of the month you would like your payments withdrawn from your account _____
Routing Number _____ Account Number _____
Name(s) on the Account _____
Bank Name _____
Bank Branch Address _____
➤ Signature(s) from all account holders _____

SPONSOR SIGNATURE

Note: **Recurring payment** – By setting up a recurring payment, you have the flexibility to pay your premium by electronic funds transfer (EFT) from your savings or checking account, or by credit or debit card. **If paying by electronic funds transfer (EFT) from your checking account, please attach a voided check to this authorization. If paying by electronic funds transfer (EFT) from your savings account, please attach a bank letter on bank letterhead, listing routing number and account number.** Signatures are required from all account holders. *This authorization is to remain in full force and effect until you notify your bank or notify the payee of its termination by canceling any pending payments and recurring payment instructions at least three banking days before your account is scheduled to be debited.*

Note: In the event that a payment is returned for insufficient funds, you authorize the payee to electronically debit your bank account for the original amount of the transaction, as well as a returned fee, up to the maximum amount allowed by law.

➤ Sponsor Signature _____ Date _____

MAILING ADDRESS

Please send signed Authorization and voided check or bank letter, if necessary, to the below address:

MetLife TRICARE Dental Program
Enrollment and Billing Services
P.O. Box 14185
Lexington, KY 40512