DMS

DENTAL MAINTENANCE SERVICES INC.

1429 WARWICK AVENUE* WARWICK, RHODE ISLAND* 02888 401-463-1920 * 1-800-456-8715 *FAX 401-463-6059

Longmeadow Retiree

Option #1 Direct

- ☐ *Quarterly (Submit a premium 3 times your monthly payment)*
- ☐ *Semi-Annual (Submit a premium 6 times your monthly payment)*
- ☐ *Annual (Submit a premium 12 times your monthly payment)*

Option #2 Pre-Authorized Debit-ACH monthly withdrawal

For Checking account:

Please attach a voided check for the account you wish your payments withdrawn from

Attach voided check here

For savings accounts (all information is required)

Bank Name:_____
Bank routing number _____
Account number _____

I _____hereby authorize Dental Maintenance Services, Inc. to deduct premiums as required for participation in the dental program from my checking/savings account. I understand that the payments will be deducted on a monthly basis on the 15th of the month for the upcoming month's payment. There is a transaction fee of $1.00 per withdrawal which will be included in my monthly payment. I agree to notify DMS a minimum of 10 business days prior to cancel this payment option. I am aware that if at any time my payment is returned by the bank unpaid, my coverage may lapse and may not be eligible to be reinstated.

Dental Deduction amount $ _____

Signature:_____ Date:_____
Signature and bank information is required