101 Parklane Boulevard – Suite # 301, Sugar Land, TX 77478
Toll Free 1.877.493.6282
Fax 832-415-0379

# Bank Draft Authorization

Group Name: _____

Group Number: _____

Bank Name: _____

Acct. #: _____

Routing #: _____

I authorize FCL Dental (First Continental Life) to charge the above account monthly for premiums due.

Signature: _____

*Please Check One:*

For One-Time Payment Only ☐

For Monthly Payments ☐

The Automatic Bank drafts are processed on the 10th of every month for monthly payments. However, if the 10th falls on a Saturday, Sunday or bank holiday, the draft will be processed on the following business day.

I hereby request and authorize FCL Dental to deduct a monthly fee from my account with the financial institution named above. This authority is to remain in effect until revoked by me in writing and until said written notice is actually received by FCL Dental. I agree that FCL Dental shall be under no liability whatsoever upon processing these payments in accordance with said terms.