P.O. Box 6578 Tamuning. Guam 96931
Telephone: (671)646-6012

DIRECT PAYMENT AUTHORIZATION

I, ________________________________ hereby authorize "Veiovis, LLC" to initiate debit entries/charges from my checking/savings/credit card accounts in the amount of $________________. The deduction will be on the 15'" of each month beginning on until the full payment of $____________has been received, I understand that if the Checking/Savings/Credit Card transaction is denied due to insufficient funds at any time, I will be notified by "Veiovis, LLC" and will pay an additional $35.00 service fee.

This payment will be for___________________________, VTA Member No. __________________.
(Patient's Name)

( ) **CHECKING ACCOUNT:** (Attach voided copy of deposit slip or check.)

Financial Institution ____

Account Number ____

Bank Routing Number ____

( ) **SAVINGS ACCOUNT:** (Attach voided copy of deposit slip.)
Financial Institution ____

Account Number ____

Bank Routing Number ____

( ) **CREDIT/DEBIT CARD:** (*Attach copy of the card.*) ( ) Amex ( ) Visa ( ) Mastercard

Credit/Debit Card# ____ Exp Date: ____/____

SCHEDULE OF DEDUCTION – to be charged on the 15th of each month.

Amount of Monthly Deduction: $_____________ Total Amount $__________________

First Month of Monthly Deduction ___________________
Month/Year

Last Month of Monthly Deduction ___________________
Month & year

This authorization is to remain in full force and effect until "Veiovis, LLC" has received written termination notice from me. I agree that *my* termination will be in such time and manner as to afford Veiovis, LLC and my Financial Institution a reasonable opportunity to act on it.

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS AND CONDITIONS:

- I understand that if the information provided above is incorrect and/or cannot be authorized by my financial Institution, my account balance will be sent to the collection agency.
- I understand and agree that "Veiovis, LLC" may refuse to extend the TrueAccess subscription benefits to me and my dependents until the account is paid within 30 days from delinquency and all arrears are current, otherwise the subscription agreement will terminated.
- I understand the "Veiovis, LLC" TrueAccess program requires a minimum subscription period of one year. I will provide an alternate form of payment for future monthly payments in the event I cancel this payment authorization.

PAYEE NAME ____DATE: ________________

PAYER SSN: _______________________________________ CONTACT NO:_____________________

PAYER SIGNATURE: ____

FHP/TIC Representative: __________________________________ DATE: ______________________

FHP/TIC Supervisor/Manager: ______________________________ DATE: ______________________