VEIOVIS
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 30th 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 30th 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 Veiovis Direct 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 be terminated.
• I understand the "Veiovis, LLC" Direct 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: _____