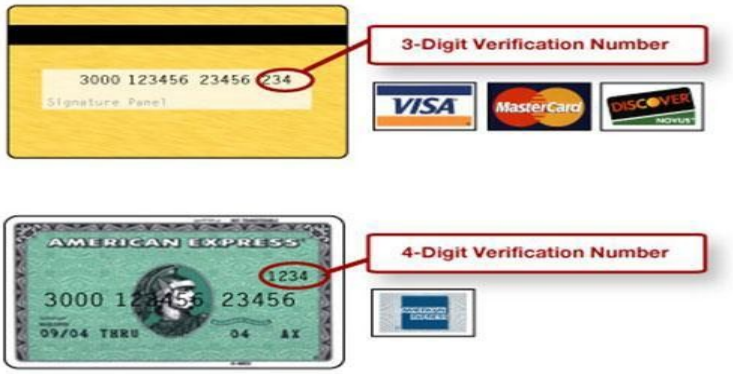
ACH Payment Form

Auto-Recurring Payment Authorization Form

Credit Card Account



Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

3 Digit Verification Code: _____

Type of Credit Card: **Master Card** ☐ **Visa** ☐ **Discover** ☐ **American Express** ☐

_____ _____

Signature of Enrollment Applicant Date

You authorize regularly scheduled monthly charges to your checking/credit card account. A receipt for each transaction will be automatically emailed to you with the contracted fee amount you have agreed to.

ACH Debit | Authorization Form

Five Points Benefit Plans, LLC

Payment Plan Authorization

Name: _____
Please print First Middle Last

Address: _____ Date of Birth: _____

City/State/Zip: _____ Last 4 digits of Social Security #: _____

Home Phone: (_____) _____ Driver's License #: _____N/A_____

Work Phone: (_____) _____ Driver's License State: _____N/A_____

Payment Plan Schedule

☐ One-time Payment Payment Amount:$_____ Payment Date: _____

☐ Recurring Debit every: _____ ☐ Day(s) ☐ Week(s) ☐ Month(s)

Start Date: Month: _____ Day: _____ Year: _____ Payment Amount:$ _____
(Start date must be at least 15 business days from submission of this form)

End Date: Month: _____ Day: _____ Year: _____ Transaction Fee:$_____

Number of Payments: _____ Total Payment: $_____
(Payment Amount + Transaction Fee)

Customer Bank Account Information:

Bank: _____ Phone Number: (_____) _____

Routing Number: _____

Account Number: _____

Attach a voided check to this form.

Payment Authorization

I authorize my bank to debit my account as identified above to the terms stated here. This authorization shall remain in effect until the Service Provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the Service Provider and bank reasonable opportunity to act (Minimum 30 days).

I understand that if the total amount owed to the Service Provider is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed the Service Provider is paid off, or unless the plan is terminated earlier by me as above. I understand any added amounts can be applied for with a new ACH Debit Authorization Form.

All other changes such as payment amount, frequency, bank account number change, will require a new ACH Debit Payment Authorization Form to be filled out and submitted to Merchant 15 days prior to any change being implemented. I understand that this payment plan may be cancelled by the Service Provider or Merchant due to NSF (Non-sufficient Funds). I will be liable to pay an NSF fee of $25.00 (or the amount allowable by law), which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the bank, and Merchant harmless from damage, loss or claim resulting from all authorized actions hereunder.

Customer Signature: _____ **Date:** _____

Second Authorized Signature of Bank Account if Required: _____ **Date:** _____

A voided check from customer's bank account must accompany this authorization form.

Five Points thanks you for trusting us with this information as it would be valuable to processing your monthly or annual payment for receiving benefits and maintaining your membership eligibility. To send us this information it can be done via email or through fax.

Thank you, we appreciate your trust and loyalty!

FOR QUESTIONS PLEASE CONTACT:

Five Points Health Benefit Plans, LLC.
6006 North Mesa Street – Suite 108
El Paso, TX 79912

Phone: 915-803-4198
Fax: 915-519-0261

Forms can be sent via mail or fax to the address above