HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

Member Payment Form

Member Information

Name			
Address	City	State	Zip Code
Contact Person	Phone	Email Address	

Payment Options

☐ **Direct Debit**

Routing Number	Account Number
Financial Institution	
Name on Account	**Notes:** **Due to processing time (30 days), first payment must be made by check.**

☐ **Credit Card** **Please Select:** ☐ Visa ☐ MasterCard

Name on Card (Last, First, M.I.)	
Card Number	Expiration Date

An additional $5.00 processing fee will be added to any credit card charge.

Payment Length

☐ **Monthly**	☐ **Quarterly**	☐ **Semi -Annually**	☐ **Annually**
In the Amount of: $	In the Amount of: $	In the Amount of: $	In the Amount of: $

Authorization

Authorization Agreement for Direct Pay: I hereby authorize Healthplex to initiate direct debits from my bank account for premium payment, and I authorize my financial institution to debit my account for such payments. I understand that the monthly direct debit of the invoiced amount will be processed approximately on the 5th business day of each month. I also understand that three (3) business days (in writing) are required to deactivate Direct Pay.

Authorized Signature	Print Name
Title	Date

"PLEASE PRINT OR TYPE ALL INFORMATION"

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