Billing Application

Requested effective date (mm/dd/year) ____/____/____

Billing Information – Invoices should be sent to:

_____

Contact Person **Title**

_____

Company Name

_____

Address

_____

City **State** **Zip Code**

_____

Telephone **Fax**

Representative: _____

Payment

☑

OPTIONS:
DELTA DELTA PREVENTIVE
DELTA DELTA 1500

EFT AUTHORIZATION

Please Note there is a $30 Insufficient Funds Fee

Bank Route Code#_____ Bank Account#_____

Please deduct payment of $_____ between the 20th & 30th of the month Prior to the next months coverage.

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by sending written notification by fax to (914) 428-8080 three (3) business days or more before this payment is scheduled to be made.

Please be aware that your bank statement will reflect the debit as Elevate Wellness Association

Date: ____/____/_____