Check / Credit Card Authorization Form

Schedule your payment to be automatically charged to your checking account or credit card. Just complete and sign this form to get started!

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your Checking Account, Visa, MasterCard, American Express or Discover card. You will be charged each billing period for the total amount due for that period. The charge will appear on your banking or credit card statement. You agree that no prior- notification will be provided.

Choose Product Below:

O $14.95 Protection+ Supplemental Loss & Damage Monthly Option	O $179.40 Protection+ Supplemental Loss & Damage Yearly Option
O $21.95 Secure Plan Supplemental Repair Warranty Monthly Option	O $263.40 Secure Plan Supplemental Repair Warranty Yearly Option
O $14.45 Protection+ Supplemental Loss & Damage Monthly Option (Single Aid)	O $174.40 Protection+ Supplemental Loss & Damage Yearly Option (Single Aid)
O $21.45 Secure Plan Supplemental Repair Warranty Monthly Option (Single Aid)	O $257.40 Secure Plan Supplemental Repair Warranty Yearly Option (Single Aid)
O $49.95 Secure+ Plan Supplemental Repair Warranty	O $599.40 Secure+ Plan Supplemental Repair Warranty

Serial # L	Serial # R	L Battery Size	R Battery Size	Chargeable	L Warranty Exp	R Warranty Exp

Please complete the information below:

I,_____authorize **Health Services Protection Plan** to charge my checking account or credit card indicated below on the_____of each month for payment on the **Health Services Protection Plan** Care Program.

Billing Address:_____Phone #: _____
City, State, Zip:_____Email:_____@ _____

Account Type: (circle one) VISA / MC / Discover / AMEX / Check

Name_____Account #: _____

Exp Date:_____CVV Number (3 digit # on back of VISA/MC/Discover, 4 digit on front of AMEX) _____

If paying by check, please attach a voided check to this form.

Bank_____Check #_____Routing # _____

Account #_____Driver's License/ State Issued ID #_____State _____

Signature:_____**Date:** _____

I authorize Health Services Protection Plan to charge the bank account or credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any change in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this bank account or credit card and that I will not dispute the scheduled payments with my bank or credit card company provided the transactions correspond to the terms indicated in this authorized form. I understand that this payment plan may be canceled 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.