NuAxess

Account Services

DR. BOGHADADY GYNECOLOGY OFFICE
11 Getty Ave
Paterson, NJ 07503

New Premium Payment options available using the MyNuAxess Automatic Premium Payment Program!

Never worry about you premium payments being made on time by enrolling in the Automatic Premium Payment Program.

Each month your premiums will be auto debited from your bank on the payment due date. You will continue to receive your invoice each month via email but the payment process will be automatic.

Just fill out and sign the ACH payment authorization form attached to this statement, scan it, and email it back to billing@MyNuAxess.com

We will contact you to confirm your enrollment.

Note: Your payment due date many be adjusted to a date a few days later to comply with bank scheduling requirments.

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Monthly Statement

DR. BOGHADADY GYNECOLOGY OFFICE
11 Getty Ave
Paterson, NJ 07503
mboghdady1@yahoo.com

Invoice Number:	DR.2022-04
Invoice Month:	APRIL
Billing Date:	03/15/2022
Payment Due Date:	03/31/2022

PLAN	COVERAGE	QTY	PRICE	TOTAL
DENTALGUARD PREFERRED	Employee & Spouse Only	1	$78.66	$78.66
Platinum	Employee & Spouse Only	1	$1,667.60	$1,667.60
VSP CHOICE	Employee & Spouse Only	1	$11.48	$11.48
			GRAND TOTAL	$1,757.74

Primary ACH Instructions:
Account Name: Nuaxess Account Services
Bank: 5/3 Bank
Routing Number 071923909
Account Number: 7242568934
Bank Address:
38 Fountain Square Plaza
Cincinnati, OH 45263

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CURRENT MONTH ENROLLMENT

MEMBER NAME	EFF DATE	PLAN	COVERAGE	PRICE
BOGHDADY, MAGED	03/01/2021	DENTALGUARD PREFERRED	ES	$78.66
BOGHDADY, MAGED	03/01/2021	VSP CHOICE	ES	$11.48
BOGHDADY, MAGED	03/01/2021	Platinum	ES	$1667.60

Employee Only	0
Employee & Spouse	1
Employee & Children	0
Family	0

Automatic Premium Payment Program

Authorization Agreement

PLEASE COMPLETE THE FOLLOWING - Print or type information

Yes, I elect to have my insurance premium paid monthly through the NuAxess Account Services Automatic Premium Payment Program

Company Name: _____

Address: _____

City: _____ State: _____ ZIP: _____ Phone #:_____

Account Holder Name(s): _____ Phone #:_____

Account Holder Address: _____

Full Name and address of Bank or Financial Institution:

_____

Bank Account Number: _____ Checking OR Savings

Bank Routing Number:_____

Please ensure that NuAxess Account Services is authorized to debit this account through your institutions block & filters security.

I, as account holder or authorized signer, hereby authorize NuAxess 2 Inc and/or NuAxess Account Services Company (GEX) to initiate withdrawals on a monthly basis from my account at the financial institution named in this authorization for payment of monthly NuAxess, Open Axess Cigna, Guardian, Vision Care, insurance premium due for the named policyholder; and I authorize the financial institution to charge such withdrawals to my account.

A draft shall be drawn each month on or about the premium due date of the policy/contract. As the account holder, by signing below, I also certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction

I understand that both the financial institution and NuAxess 2 Inc and/or NuAxess Account Services reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program (except on individual temporary contracts) at any time with at least 10 days advance notice to NuAxess and /or NuAxess Account Services by email, online portal, and or telephone prior to a scheduled withdrawal date.

I am authorizing my insurance premium due for this NuAxess coverage, be paid as described in this agreement and agree that if any withdrawal is dishonored, the premium payment for such withdrawal will be considered in default. I also authorize the disclosure of my policy identification/group numbers and any other necessary personal information on the financial institution's statements to identify to the account holder named for whom withdrawals are being made.

I have read and accept the above agreement.

Authorized Signature: _____

Date: _____

This agreement is valid till the anniversary date of your policy and must be renewed at that time.

Send Completed Authorization form to:

NuAxess Account Services
billing@MyNuaxess.com
Or
Jeff Lozinski
1501 Woodfield Rd, Suite 114E
Schaumburg IL 60173
Jeff@NuAxess.com