



Account Services

Monthly Statement

COMMODORE CLUB WEST

,
andrea@ccwcondo.com
niurka@ccwcondo.com

Invoice Number: 4972-2205
Invoice Month: MAY
Billing Date: 04/15/2022
Payment Due Date: 04/30/2022

PLAN	COVERAGE	QTY	PRICE	TOTAL
PLAN 1	Employee Only	10	\$415.00	\$4,150.00
ADJUSTMENT	APRIL BINDER PEREZ ANGEL			\$415.00
ADJUSTMENT	APRIL BINDER GARACHANA, FREDY			\$415.00
			GRAND TOTAL	\$4,980.00

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

COMMODORE CLUB WEST

,

CURRENT MONTH ENROLLMENT

MEMBER NAME	EFF DATE	PLAN	COVERAGE	PRICE
ARAGON, SCARLETH	07/01/2021	PLAN 1	EE	\$415.00
AYALA, LARRY	09/01/2019	PLAN 1	EE	\$415.00
GARACHANA, FREDY		PLAN 1	EE	\$415
MESA, REINALDO	09/01/2019	PLAN 1	EE	\$415
MUNOZ, NIURKA	09/01/2019	PLAN 1	EE	\$415.00
PEREZ, ANGEL		PLAN 1	EE	\$415
PINA CASANAS, VLADIMIR	09/01/2019	PLAN 1	EE	\$415.00
RAUDALES, ANDREA	06/01/2021	PLAN 1	EE	\$415.00
SANCHEZ, JESUS	09/01/2019	PLAN 1	EE	\$415.00
URBINA, GURSTAVO	09/01/2019	PLAN 1	EE	\$415.00

Employee Only	10
Employee & Spouse	0
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 NuAcess 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 NuAcess Account Services is authorized to debit this account through your institutions block & filters security.

I, as account holder or authorized signer, hereby authorize NuAcess 2 Inc and/or NuAcess 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 NuAcess, Open Axxess 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 NuAcess 2 Inc and/or NuAcess 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 NuAcess and /or NuAcess Account Services by email, online portal, and or telephone prior to a scheduled withdrawal date.

I am authorizing my insurance premium due for this NuAcess 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