dsi

Dental Services Inc.

278 S. Marine Dr. Suite 105, Tamuning Guam 96913
Tel. (671) 646 DSI1 (3741) fax. (671) 646 3740 ● www.guamdsi.com

CREDIT CARD AUTHORIZATION APPLICATION

Date of Request_____

I, _____ authorize Dental Services Inc. to manually debit my credit card the amount of $_____, on the first day of every month for a period of ____month(s).

Beginning the first day of ___/___/201__, to the first day of ___/___/201__. I understand that if the first falls on a non-business day, DSI will debit my credit card the next business day thereafter.

I understand that if there are any changes to my DSI account that directly affects the monthly contribution authorized above, it is my responsibility to provide DSI an updated credit authorization to continue such debits. Should my account default in payment due to insufficient funds or closure of my credit card account, I will face a fee of $45.00 in addition to the monthly contribution due. Failure to make your monthly contribution by the 1st week of every month, you will accrue a $10.00 late fee. DSI is not responsible for the penalties accessed by the cardholder from the credit institution for overextension on their credit limit.

My card information is as follows: (Visa and Mastercard accepted)

Name of Card Holder: _____

Name of Subscriber: _____ (if different from card holder)

Type of card: ☐ Visa ☐ Mastercard

Card Number: _____

Expiration Date: _____ Month _____ Year

I understand and accept DSI's policy for Credit Card Authorizations and acknowledge my responsibility specified above.

Signature of Card Holder: _____ Date Signed: _____

FOR DSI USE ONLY

DSI Subscriber Number:	Coverage Effective:
Dependent Mbr. Number:	Coverage Expires:

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ACH DEBIT PROGRAM APPLICATION

_____("Bank") is authorized to pay and debit to the account of the undersigned all payments drawn by or on behalf of Dental Services Incorporated or its assignee, including those in the form of magnetic tape. The undersigned agrees that the Bank, and not the Lessor, will be liable for any loss or damage incurred as a result of anything done or not done pursuant to this authorization. If the account is transferred to another branch or the account is closed and an account is opened by another bank, this authorization shall have the same force and effect as if it had originally directed to that branch or bank, as the case may be. This authorization is given in accordance with the terms of a lease or leases with or other obligations to make payments to Dental Services Inc. or its assignee.

Your bank account will be charged with the monthly balance due and Dental Services Inc. or its assignee's account will be credited. Initially a zero-dollar pre-noting transaction will be processed. As a courtesy, you will be given notice of the first date this will go into effect. Should my account default in payment due to insufficient funds or closure of my credit card account, I will face a fee of $45.00 in addition to the monthly contribution due. Failure to make your monthly contribution by the 1st week of every month, you will accrue a $10.00 late fee.

Account Holder Name (Please Print):

_____

DSI Subscriber Name (Please Print):

_____

SSN of Account Holder: _____ Date of Birth:_____

PO Box or Residential Mailing Address: _____

Bank Name: _____ City_____ State _____ Zip Code _____

Bank Routing Number:_____ Account Number: _____

Authorized Monthly debit amount $_____ ☐Checking(Void check or deposit ticket needed) ☐Savings

Initial Transaction (Month/Year) ___/201__ Final Transaction (Month/Year) ___/201__

Authorized Account Holder Signature: _____ Date: _____

NOTE: Please provide a void check, Thank You☺

FOR OFFICE USE ONLY

Originated by:	Notice given by:
Date received:	Pre-note transaction date:
Input date:	Actual pre-note date:
Due date:	1st charge transaction date:
Date notified:	Actual 1st charge date: