dsi

Dental Services Inc.

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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 ___/___/202__, to the first day of ___/___/202__. 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 and 2% finance charge. 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 _____ CVC / CVV

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: