HealthCap® RRG

Recurring ACH Authorization

ACH Recurring Payment Authorization Form

Please complete the information below:

I (we) authorize **HealthCap RRG** to initiate recurring payments from my (our) checking/savings account and, if necessary, initiate adjustments to these transactions for any amount credited/debited in error. **These payments pertain to policy HRG-**

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(Name - PLEASE PRINT)

____

(Address - PLEASE PRINT)

Phone: ________________________ Email ______________________________________

Please indicate if you would like the deposit and/or installments paid per this agreement by checking one or both fields below:

☐ Deposit Amount______________to be processed on business day ________ of the month of_________, 2021.

☐ Installment Amount _____________to be processed on business day ________ of the month of_________, 2021.

Account Type: ☐ Checking ☐ Savings

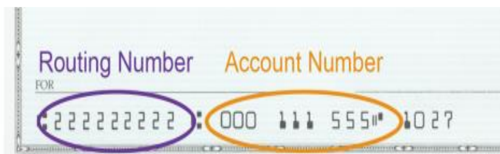
Name on Acct ________________________________

Bank Name ________________________________

Account Number ________________________________

Bank Routing # ________________________________

Bank City/State ________________________________



HealthCap RRG policy ______________________________

SIGNATURE ____ DATE ____________________

I understand that if the above noted payment date(s) fall(s) on a weekend or holiday, the payment may be executed on the next business day. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that HealthCap RRG may, at its discretion, attempt to process the charge again within 30 days. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

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Upon completion of this form, please email, to: HealthCap Billing Support at billing@healthcapusa.com