HealthCap RRG

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 HealthCap RRG policy as described below.**

(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_____, 20_____

☐ Installment Amount _____to be processed on business day _____ of the month of_____, 20_____

Account Type: ☐ Checking ☐ Savings

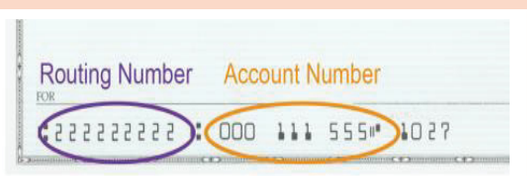
Name on Account :

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.

Upon completion of this form, please email to: billing@healthcapusa.com