



# Payment Authorization Form

Primary applicant name Migdalis Silva	Policy number 051726557
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Payment Frequency	Initial Premium	Monthly Premium
MONTHLY	\$19.99	\$19.99

Payment Type	
<input checked="" type="checkbox"/> Automatic Credit card payment <i>(If elected, complete Section A and sign and date Section C)</i>	<input type="checkbox"/> Automatic bank draft/ACH payment <i>(If elected, complete Section B and sign and date Section C)</i>

A. Automatic credit card payment information and authorization		
Card type <input type="checkbox"/> MasterCard <input checked="" type="checkbox"/> Visa <input type="checkbox"/> Discover	Name—as it appears on the card Migdalis Pabon Silva	Relationship to proposed insured Apolicant
Card Number *****3742	Expiration date 1/2023	

B. Automatic bank draft/ACH payment information and authorization	
Account type <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account holder name
Name of bank	Relationship to proposed insured
Routing number (from your check as shown below)	Account number (from your check as shown below)

Jane Doe 2139 S. 33 St. AnyTown, USA 12345		1234
Date: _____		
PAY TO THE ORDER OF _____	\$ _____	
		DOLLARS
Bank Name		
Memo _____		
(Routing #)	(Account #)	

C. Signatures	
<p>I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify The Loomis Company or its designated administrator in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that The Loomis Company or its designated administrator may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. 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 recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.</p> <p>If applicable, premium will be debited immediately following receipt of the form.</p>	
<u>X Migdalis Silva</u> Signature of account holder	<u>02/26/2019</u> Date



## RX Pay Card Application

Effective date

02/27/2019

Monthly premium

\$19.99

### A. Primary Member Information

Name	Date of birth	Marital status	Gender
Migdalís Silva	11/14/1983	<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single	<input type="checkbox"/> M <input checked="" type="checkbox"/> F
Email	Home telephone number	Work telephone number	
migdalisch32@gmail.com	(862) 270-8609		
Mailing address	City	State	Zip code
12485 SW 137 AVE SUITE 208	MIAMI	FL	33186
Billing address	City	State	Zip code

### B. Dependent Information

Name (last, first, MI)	Gender	Relationship	Date of birth
	<input type="checkbox"/> M <input type="checkbox"/> F	Spouse	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child	
	<input type="checkbox"/> M <input type="checkbox"/> F	Child	

### C. Applicant Authorization

I hereby apply for enrollment in The Loomis Company, prescription program. I understand that acceptance of this enrollment is guaranteed. I understand that the earliest my enrollment can become effective is the day after receipt of the completed enrollment form and the first month's payment. I also understand that by participating in this program external factors may force a change in monthly fee, benefits and/or preferred drug list at any time. I will be entitled to negotiated and funded discounts on eligible prescription drugs purchased from any participating pharmacy. I have the right to request certain information about my medical or personal history not be shared with third parties. NOTE: The pharmacy benefit manager will without your consent or authorization submit online pharmacy claims data to manufactures, with NO member identification, for the payment of the rebates. Online claims data will also be provided to employers and pharmacies regarding invoicing and payments in the standard NCPDP claims billing format. If you have signed up for online reminders regarding refills or your current medications, emails will be sent to you directly at the email address you list on your enrollment application. If you wish to revoke the right for us to use your personal health information, you must contact The Loomis Company at 866-218-6016 or visit [www.loomisco.com](http://www.loomisco.com). Revoking the right for us to use your personal health information may also terminate your benefits. Signature authorizes release of information and enrollment into the program. The enrollment kit is sent via email. We do not have preprinted materials.

I acknowledge that I have read the completed application and want to apply for this coverage.

Primary member signature	Date
<i>Migdalís Silva</i>	02/26/2019

### D. Producer Information

Name	Signature
AMED GARCES	AMED GARCES
Email	Phone
AHMEDGARCES@GMAIL.COM	
	Date
	02/26/2019