

Automatic ACH Withdrawal Authorization Form

www.MedicalAlertDiscount.com

Fax to: (800) 516 – 2295

ATTENTION: This authorization allows Valued Relationships, Inc. to process your monitoring payments via automatic electronic draft withdrawal each month from your checking or savings account. Your service order can NOT be processed until this documented is completed and sent back to us.

- INSTRUCTIONS:**
1. Please complete and return the attached form.
 2. Sign your name(s) as it appears on your account.
 3. For withdrawal from checking accounts, please attach a VOIDED personal check.
 4. Fax to: **(800) 516 – 2295**, OR scan and email to: mmartin@LiveAtHomeMonitoring.com

The monitoring service is for:

Patient Name: _____ Patient Home Phone: (_____) _____

AUTHORIZATION TO WITHDRAW FUNDS

Please check one of the following: _____ Checking _____ Savings

As a convenience to me, I hereby authorize Valued Relationships Inc. (VRI) to make automatic payment withdrawals of \$25.47 per month from my selected Checking or Savings account by automatic electronic debit entry. VRI is further authorized to make an initial one-time withdrawal of \$0 (zero) for the enrollment or past due amounts.

BANK INFORMATION:

Bank Name: _____

Account Holder Name: _____

Electronic Routing Number: _____

Checking / Savings Account Number: _____

I acknowledge that there will be a \$25.00 processing fee for any declined charges due to insufficient funds in the account. This authorization is to remain in effect until further written notice.

The charge on your bank statement will appear as: Valued Relationships, Inc.

Customer Signature: _____ Date: _____ Thank you!!!

VRI Use Only: _____

Place VOIDED check here or on separate page