TIER 1
HEALTH AND WELLNESS

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Recurring ACH Payment Authorization

I authorize regularly scheduled charges to my checking/savings account. I will be charged the amount indicated below each billing period. The charge will appear on my bank statement as an "ACH Debit". I agree that no prior notification will be provided unless the date or amount changes.

I _____ authorize _____ to charge my (Full Name) (Merchant's Name)

bank account indicated below for $_____ on the _____20th_____ of each month. (Amount $) (day)

Billing Address _____ Phone # _____ City,

State, Zip _____ Email _____

Bank Details

☐ Checking ☐ Savings

Account Name _____

Bank Name _____

Account Number _____

Routing Number _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Tier 1 Health and Wellness 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 payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates.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 Tier 1 Health and Wellness may at its discretion attempt to process the charge again within 30 days, and agree to an additional $50 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 certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____