Republic Pharmaceuticals
5840 Interface Dr. Ste. 200
Ann Arbor, MI. 48103
Hours: Monday- Friday 10am-5pm

Email: customerservice@republicpharma.com
Phone: 800-659-6609 ext.113
Fax: 800-671-9980

Recurring/Backup Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard or American Express. Just complete and sign this form to get started!

NET 30-CHECK ☐ Check paying customers must list a **backup** form of payment below.

Why choosing Recurring Payments is better:

- It's convenient (Save time and postage)
- Your payment is always on time (Even if you're out of town!), eliminating late charges
- Product ordered on the 1st- 25th is drafted as ACH on the 10th of the following month

Recurring/Backup Payment Terms:

You authorize charges to your bank account or credit card. Recurring payments will be collected for open invoices on your account each billing period. A receipt will be emailed to you and the charge will appear on your bank statement. Customers whose checks are not received within 15 days of due date will have their backup form of payment charged. Credit Card payments are collected at Point-of-Sale. **No prior-notification will be provided for any form of payment.**

Please complete the information below:

Medical Facility or Pharmacy Name: _____

Billing Address City, State, Zip: _____

Phone Number: _____ Email (required): _____

Checking/ Savings Account

☐ Checking ☐ Savings

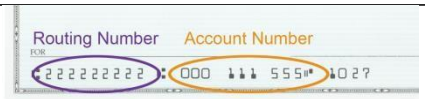
Name on Acct: _____

Bank Name: _____

Account Number _____

Bank Routing # _____

Bank City, State _____



Credit Card

☐ Visa ☐ MasterCard

☐ Amex

Business Cardholder Name **as It Appears on the Card**:

_____

Card Number: _____

Exp. Date: _____ CVV: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Republic Pharmaceuticals 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 Republic Pharmaceuticals 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 credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

Print Name _____ **SIGNATURE**_____ **DATE:**_____