

TeleMedicine Agreement for List Billing

ENTITY INFORMATION

Practice _____

Address _____

Address 2 _____

City, State, Zip _____

Phone _____

FEIN/Tax ID _____

Membership Effective Date _____

Number of Eligible Members _____

Membership Kits Sent To Employee(s) _____

Payment Process Employer Paid _____

BILLING CONTACT

Name _____

Email _____

Phone _____

ELIGIBILITY CONTACT

Name _____

Email _____

Phone _____

MEMBER CONTACT (Questions/Cancellations)

Name _____

Email _____

Phone _____

TDA Insurance Agency, Inc. (TDAIA) will email a list bill to the employer on or about the 20th of each month. Any changes (additions or cancellations) need to be reported to TDAIA before the 1st of the month. The payment of the adjusted invoice will be deducted from your checking account on the 2nd working day of each month. Employer will not pay for any employee cancelled before the last business day of each month. Conversely, a credit will not be allowed for any reason if the employee is not cancelled before the last business day of each month.

PAYMENT INFORMATION

I choose to pay by electronic draft.

Account Holder: _____ Type: Checking Savings

Name of Bank (Include City & State): _____

ABA Routing Number (#s at Bottom of Check): _____

Account Number: _____

CONFIRMATION

I authorize TDA Insurance Agency, Inc. (TDAIA) to initiate debit entries electronically to my account indicated above and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until TDAIA has received notification from me of its termination in such time and in such manner to afford TDAIA and the depository/institution a reasonable opportunity to act on it.

Signature

Date (MM/DD/YY)