EMPLOYER Billing Application

Mail to: DIME Medical
340 Main Street
Darlington, WI 53530
Fax to: (855) 574-5406
Phone: (608) 482-2005

Employers Name: _____ Date:_____

Company Name:_____ Phone:_____

Address for mailing:_____

_____

_____

Above name should be payor for employees listed below:

1	4
2	5
3	6

Or "See Attached List of names"

CHOOSE WHAT PARTS YOU are going to pay for your employees AND what percentage.
0% --- 50% --- 100%. Remaining percentages will be assumed to be paid by employee.

Registration - ONE TIME fee $25 per member	**MEMBERSHIP** SUBSCRIPTION This is the major recurring fee	**Laboratory sendout fees (discounted)**	**Prescriptions** NOT AVAILABLE in 2019	**Miscellaneous charges** NONE in 2019
%	%	%		

Discount PAYMENTS:

Membership	**12 months 5.0%**	**6 months 2.5%**	**3months 1.0%**
Adult $50	$570	$292.50	$148.50
Child $25	$285	$146.25	$74.25
Family $150	$1,710	$877.50	$445.50

COST for FULL 12 MONTHS

Membership	**12 months 5.0%**	**6 months 2.5%**	**3months 1.0%**
Adult $600	$570	$585	$594
Child $300	$285	$292.50	$297
Family $1,800	$1,710	$1755	$1,782

version 1/1/2020

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CHOOSE A METHOD OF PAYING

1. **AUTOMATIC *BANK DEDUCTION* for membership fee and any charges:**

Name of bank:_____

Account holder name:_____

Routing Number:_____

Bank Account Number: _____

I authorize the direct bank deduction from my bank account to pay the Membership Fee:

_____ Every Month, _____ Every 3 months, _____ Every 6 months, ____ Every year

On the ____ 1st, _____5th , ____10th, ____15th, ____ 20th, ____25th of the month

Signature: _____ Date:_____

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2. **AUTOMATIC *CREDIT CARD* payment of Membership fee and any charges:**

Name on Credit Card: _____

Credit Card Number: _____ CVC: _____

Expiration Date:_____

_____ Every Month, _____ Every 3 months, _____ Every 6 months, ____ Every year

On the ____ 1st, _____5th , ____10th, ____15th, ____ 20th, ____25th of the month

Signature: _____ Date:_____

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3. MANUALLY pay each payment period of membership fee and any charges:

____ Personal Check, _____ Manual Credit Card payment, ____ Cash

Every: ____ Month, ____ Every 3 months, ____ Every 6 months, ____ Every Year

Please send me a bill for the charges. Payment is due be BEFORE services period begins.

Signature: _____ Date:_____
