



2000 W University  
 Siloam Springs, AR 72761  
 479.524.7303

Member ID: M-\_\_\_\_\_  
 Credit Card Type: \_\_\_\_\_  
 Last Four Digits: \_\_\_\_\_  
 Expiration: \_\_\_\_/\_\_\_\_  
 Rec'd By: \_\_\_\_\_  
 Date: \_\_\_\_\_

## Monthly Pre-Authorized Payments



Schedule your membership payment to be automatically charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

### Pre-Authorized Membership Payment Benefits:

- *It's convenient (saving you time and postage)*
- *It's budget friendly (allowing you to spread out your membership expense instead of paying for 3 months up front)*
- *Your payment is always on time (even if you're out of town), preventing expiration of your membership*

### Here's How Pre-Authorized Payments Work:

You authorize regularly scheduled charges to your credit card at your monthly membership rate. Your card will generally be charged between the 1<sup>st</sup> and 5<sup>th</sup> day of the month for the current month's membership. No advance notification will be provided prior to the payment being collected. To cancel your pre-authorized payment, you must submit a signed cancellation form to the WLHC Membership Office by the 25<sup>th</sup> day of the month prior to the month designated for cancellation. If your card is declined, we will ask you to provide a new card within a week of the decline or your membership will be cancelled.

### Please complete the information below:

Head of Household's Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

I, \_\_\_\_\_, authorize the Walton Lifetime Health Complex to charge my  
 (full name)

credit card in the amount of \$ \_\_\_\_\_ every month between the 1<sup>st</sup> & 5<sup>th</sup> day for my

\_\_\_\_\_ membership.  
 (type of membership)

I understand that this authorization will remain in effect until I cancel this agreement by submitting a signed cancellation form by the 25<sup>th</sup> day of the month prior to month designated for cancellation. Cancellation forms received after this date will not be processed until the next billing cycle. Refunds for membership payments that have not been cancelled via the aforementioned process will not be granted.

I agree to notify the Walton Lifetime Health Complex of any changes in my account, including updated expiration dates. Declined transactions will result in membership cancellation if corrected card information is not supplied.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company so long as the transactions correspond to the terms in this authorization form.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_