Membership Billing Application 2023+

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

Primary Payor Member Name (for family):_____Date:_____

I wish for Membership to be:

_____ ONE MONTH ONLY, then I understand that my membership will be suspended, and I may return in future but will have to repay the Enrollment fee to do so.

_____ Continuous Membership, Until I notify DIME Medical to suspend my membership.

_____ Other memberhip duration:_____

Payment Interval CHOOSE ONE:

_____ Every Month, _____ Every 12 months, _____ Every 6 months, ____ Every 3 mon

Discount PAYMENTS

Membership	12 months 5.0%	6 months 2.5%	3months 1.0%
Adult $55.00/month	$627.00	$321.75	$163.35
Child $27.50/month	$313.50	$160.88	$81.68
Family $165.00+ (1) /month	$1,881.00 + (1)	$965.25+ (1)	$490.05+ (1)

COST for FULL 12 MONTHS

Membership	12 months 5.0%	6 months 2.5%	3months 1.0%
Adult $660/yr	$627.00	$643.50	$653.40
Child $330/yr	$313.50	$321.75	$326.70
Family $1,980+ (1) /yr	$1,881.00+ (1)	$1930.50+ (1)	$1,960.20+ (1)

(1) Family = 2 Adults + 2 - 4 legal children + $11.00 per additional child per month

---

ON the next page choose EITHER <u>Automatic</u> payments or <u>Manual</u> payments.

Automatic payments are then deducted from your Bank Account OR charged to your Credit Card.

Your bank account must be “verfied” by you, reporting to us, of two small transactions from Atlas MD to your account, before we can begin deduction.

version 12/5/22

Membership Billing Application 2023+

1. *AUTOMATIC PAYMENTS*
Please choose date closest to Membership Start date
- Chose ONE:

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

-Choose ONE:

Automatic Bank Deduction for membership fee and any charges:	**____Automatic / ____Manual Credit Card payment of Membership fee and any charges:**
Name of bank:_____ Account holder name:_____ Routing Number:_____ Bank Account Number: _____	Name on Credit Card: _____ Credit Card Number: _____ CVC: _____ Expiration Date:_____

2. Manually pay each payment period of membership fee &any charges:
Payment is due be BEFORE service period begins. 30 day grace period before membership is suspended if unpaid - waiver at discretion of DIME Medical.

____ Personal Check, ____Cash, ____ Manual Credit Card payment only when individually authorized (enter info above card)

Please send me an invoice for the charges by: _____Email, _____Mail

Email account to use:_____

Address to use: _____

I authorize the direct bank deduction or Credit Card charge on the account listed in the preceding according to my choices, to pay the Membership Fee and any other fees/charges from DIME Medical:

Signature: _____ Date:_____

version 12/5/22