בס"ד

Payment by credit card

Maccabi Health Care Services

Name of the student_____

Father's Name_____

Name of the card holder_____

Passport no. of the card holder

Card no.

Valid until: _ _ / _ _ 3 numbers on the back

a. This assignment was signed without specifying the number and amounts of the payments, since it was given by permission to the issuer of the credit card through the "Maccabi Fund" to deduct debits from time to time, as specified to the issuer.
b. I am aware that the amounts and dates of the debits will be determined from time to time by the Maccabi fund and / or Maccabi Health Care Services ("Maccabi") by the various collection fees, including those customary at Maccabi and the additional insurance programs, including the contributions and levies I owe under the National Health Insurance Law (including visits to doctors, medical institutes and medicines), and according to the amounts determined by Maccabi, including charges for other family members / members for whom I gave my consent to pay.
c. This assignment will also be valid for charging a credit card that will be issued and will carry a different number, as an alternative to a card whose number is specified in this assignment.
d. This authorization will be terminated by a written notice from me to the credit

card company or to "Maccabi" or under any law and shall enter into force one business day after the notice to the credit card company or to "Maccabi".
e. I am aware that Maccabi is keeping to itself the right to change the collection dates, and that in such a case, a one-time collection may be made in the future after giving advance notice, for months, in order to match the collection dates to Maccabi's monthly arrangements.
f. In any case, the date on which credit / debits will be performed for my benefit / my duty by the issuing company, shall be determined in accordance with the agreement between me and the issuing company.
g. I am aware that if, on the date of signing this authorization, members for whom I pay, are already updated in the Maccabi system. These members will continue to be paid by me, and there will be no change in the composition of the members until Maccabi has received a written request from me.

This form will be returned filled and signed to the Maccabi Medical Center and after it has been returned, a Maccabi representative will contact you. Until the date of contact by the Maccabi representative, we will not make any change in the means of payment updated in the systems of Maccabi and which you are interested in replacing the credit card appearing in this authorization form. If you have not been contacted within 2 working days from the date of transfer of this signed form, please contact the Maccabi Health Care Center to which the form was sent.

Card Holder's Signature: _____