PAYMENT PLAN FORM

Caribbean Medical University

Campus: WTC Piscadera Bay, Curacao • Phone: (5999) 463-6105 • Fax (5999) 463-6405
Finance Department: 5600 N River Road Suite 800 • Chicago, Illinois 60018 United States
Phone: (888) 877-4268 • Fax: (302) 397-2092 • Email: finance@cmumed.org • Web: http://www.cmumed.org

Please complete this form and submit it to CMU's Finance Department to enroll into a monthly payment plan. Student's balance along with a 10% payment plan fee will be split into 4 installments which will be automatically charged to the credit/debit card indicated below each month starting on the date of first payment. I authorize the charges to the credit card by signing below.

Student Information

Student Name: _____
Last Name *First Name* *Middle Name*

Student ID Number __ __ __ Current Enrollment: —
As appears on ID card *Program - Semester*

Cardholder Information

Name: _____
Last Name *First Name* *Middle Name*

Address: ( )
Number and street or rural route *Apt. No.* *Area Code* *Phone Number*

City or Town *State* *Zip Code* *Country*

Credit Card Information

Credit Card Number

Expiration Date M M Y Y

Card Code *

Card Type

☐ Visa ☐ MC ☐ AMEX ☐ Discover

** three digit code on the back of the card*

4 monthly payments of *authorized amount in U.S $* . starting on __ __ / __ __ / __ __
date of first payment

AUTHORIZATION

I AUTHORIZE ABOVE AMOUNTS TO BE CHARGED TO MY ACCOUNT ACCORDING TO CARD ISSUER AGREEMENT
By signing this form, I hereby authorize Caribbean Medical University to automatically charge monthly payments of the amount specified above to my credit card account. This authorization will remain in effect for a period of four (4) consecutive months starting on the date indicated as the date of first payment or until the tuition balance has been paid in full.

I have received and accepted an itemized tuition statement detailing all of the current charges and credits applied to student's account. I further agree that in the event any of the credit card payments become declined, I will provide the CMU Finance Department with new valid credit card information upon request, to be charged for any outstanding balances owed by the student to Caribbean Medical University.

Cardholder's Signature: _____ Date: __ __ / __ __ / __ __

REV. 2/11