PRE-AUTHORIZED CREDIT CARD PAYMENT PLAN

FORM OF AUTHORIZATION

I,	*(Please print name)*
hereby authorize Family Guardian to charge	$ to my credit card #:
	, expiry date (MM/YY)

Select Card Type

☐ Visa ☐ American Express ☐ Diner ☐ MasterCard ☐ Discover

Effective: (MM/YY) , and on the day of each subsequent month for settlement of the following.

Policy #:		Policy #:	
Policy #:		Policy #:	
Policy #:		Policy #:	
Policy #:		Policy #:	
Policy #:		Policy #:	
Policy #:		Policy #:	

These instructions are to remain in effect until cancelled by myself in writing. Additionally, I also authorize Family Guardian / BahamaHealth to adjust the original amount(s), as needed due to subsequent premium increases and/or reductions to ensure full satisfaction of required policy payment(s).

X

Signature of Cardholder

Name of Cardholder *(print name)*

Postal Address:		Island:	
E-mail Address:			
Telephone:	(w)	(h)	(c)

X

Witness Signature *(Must be a Family Guardian representative)*

Witness Name *(print name)*

Dated at: (DD/MM/YY)

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