



Credit Card Authorization for First Payment

With the First Payment by Credit Card Billing option, you must select a secondary billing type/mode for subsequent premium payments. Complete the Credit Card checkbox below and the Authorization for Credit Card payment section. Select a checkbox for Check-O-Matic or Direct Bill and provide all necessary information. If selecting any of the Check-O-Matic options, the Check-O-Matic Billing section must be completed and the authorization signed.

- Credit Card: First Payment Only
- Check-O-Matic: Monthly
- Direct Bill: Quarterly Semi-Annual Annual

If billing address is different than resident address, please complete:

Payor Name	Address	City	State	ZIP
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AUTHORIZATION FOR CREDIT CARD PAYMENT

When selecting MasterCard/VISA: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

- VISA MasterCard

Credit Card Number: _____ Expiration Date: ____ / ____

Name as it appears on card: _____

Signature of Cardholder: _____ Date: _____

Cardholder Address	City	State	ZIP
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AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY — Choose the following option that applies:

- To add this policy to an existing Check-O-Matic:

Existing COM number: _____ Associated policy number: _____

- To begin Check-O-Matic withdrawals:

Select a desired withdrawal day (1-28): _____

Bank name: _____ City: _____ State: _____

Routing number - (9 digits): _____ Account number: _____

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor	Date Signed
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