ASSURANT
Health

# Credit Card Authorization

**Credit Card:** ❑ **Monthly** ❑ **Quarterly** ❑ **Semi-Annual** ❑ **Annual**

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

_____

**Cardholder Address** **City** **State** **ZIP**

**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 Signed**