ASSURANT
Health

Credit Card Payment Authorization for Recurring Payments

Assurant Health
501 W. Michigan
P.O. Box 624
Milwaukee, WI 53201-0624

☐ **New Business** — Fax completed authorization to (414) 299-6020

☐ **Existing Policy** — Fax completed authorization to (414) 299-8493

Applicant or Policyholder Name: _____

Application or Policy Number: _____

Payment Mode: ____ Monthly* ____ Quarterly ____ Semi-Annual ____ Annual
**Monthly payment mode is only available in AZ, CT, KS, NC and OH.*

AUTHORIZATION FOR CREDIT CARD PAYMENT
When selecting MasterCard/VISA: I authorize Time Insurance Company to charge my account for the Individual Medical policy listed above. This authority will remain in effect until I have notified Time Insurance Company of its termination.

☐ **VISA** ☐ **MasterCard**

Credit Card Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Expiration Date: __ __ / __ __

Name as it appears on card: _____

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

_____

Cardholder Address City State ZIP

Cardholder Phone Number: (__ __ __) __ __ __ - __ __ __ __

_____

Signature of Cardholder **Date Signed**

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Form 29208 (Rev. 1/2007)