

Health Insurance Recurring Payment Authorization

Policyholder Information

Name

Policy Number

Address

Payment Information

Payment Amount

Frequency

Start Date

Bank Account/Credit Card Type

Account/Credit Card Number

Routing Number (if applicable)

Authorization

I authorize the above-named health insurance company to automatically charge the specified payment amount to the account provided for recurring insurance premium payments. This authorization will remain in effect until I notify the company in writing to cancel. I understand that insufficient funds may result in additional fees and possible cancellation of my policy.

Signature

Date