CREDIT CARD AUTHORIZATION FORM FOR PAYMENT OF INSURANCE PREMIUM

I,	Cardholder's name		
authorize Bupa Worldwide Corporation, the insurer's managing general agent, to charge my credit card:			
☐ MasterCard ☐ Visa ☐ American Express ☐ Diners Club International			
Credit card number		Expiration date	Month/Day/Year
Amount to charge	US$		
Credit card holder's billing address (address where credit card statement is received):			
Credit cardholder's telephone number		Email address	
Renewal date	Month/Day/Year	Policy number	
Policyholder's name			
Cardholder's signature		Date	Month/Day/Year
Policyholder's signature		Date	Month/Day/Year

AUTOMATIC DEBIT FOR FUTURE RENEWALS

I hereby authorize Bupa Worldwide Corporation (hereinafter "Bupa"), the insurer's managing general agent, to directly debit the credit card that I have identified above for the payment of insurance premiums for my health insurance policy, as specifically indicated in this authorization form.

I understand that if there are any changes to my insurance policy, the amount of the premium may also change from the above-stated amount.

I further understand that a true and correct copy of this authorization will be forwarded to my credit card company and, by my signature on this document, I request and instruct them to allow Bupa to directly debit my credit card account for the payment of health insurance premiums until I instruct otherwise in writing.

I acknowledge that, in the event that the direct payment of any insurance premiums by credit card for my health insurance policy is rejected or declined for any reason, it will become my personal responsibility to immediately pay the premiums for my health insurance policy, or my policy may lapse, be terminated and/or cancelled.

With my signature below, I am authorizing automatic deduction for future renewals.

Cardholder's signature		Date	Month/Day/Year
Policyholder's signature		Date	Month/Day/Year

Please send this form via fax to +1 (305) 275 8484 to expedite the renewal process.
If you have any questions, please contact us at +1 (305) 398 7400.

17901 Old Cutler Road, Suite 400, Palmetto Bay, Florida 33157
Tel. +1 (305) 398 7400 • Fax +1 (305) 275 8484 • www.bupasalud.com/MyBupa

AUTHORIZATION FORM FOR PAYMENT OF INSURANCE PREMIUM WITH A U.S. CHECKING ACCOUNT (ACH)

Financial institution			
Bank contact			
Account name			
Account number		Routing/ABA number	
Telephone number		Amount to debit	US$
Policyholder's name		Policy number	
Policyholder's address			
City		State	ZIP code
Email address			
Account holder's signature		Date	Month/Day/Year
Policyholder's signature		Date	Month/Day/Year

IMPORTANT NOTE
To process your request, please attach a voided check.

In payment for the insurance coverage provided to me by the insurer, I hereby authorize Bupa Worldwide Corporation (hereinafter "Bupa") to initiate a debit entry to the checking account identified above, at the financial institution named above, for the amount indicated herein. I hereby acknowledge that all Automated Clearing House (ACH) transactions must comply with the provisions of U.S. law.

This authorization may be revoked by me with written notice to Bupa, which will be effective seventy-two (72) hours after receipt by Bupa. I hereby acknowledge and agree that Bupa has no control over said revocation and, accordingly, has no liability whatsoever regarding said revocation.

The undersigned hereby indemnifies and holds Bupa harmless from any claims, demands, causes of action, liabilities, damages, judgments, including the cost of defending or appealing any action against Bupa, as well as any attorney's fees incurred in the process. I further agree and acknowledge that Bupa shall not be held liable or responsible for inquiring into the propriety of any transfers of funds processed pursuant to this authorization.

AUTOMATIC DEBIT FOR FUTURE RENEWALS

I hereby authorize Bupa Worldwide Corporation (hereinafter "Bupa"), the insurer's managing general agent, to directly debit my bank account, identified above, for the payment of insurance premiums for my health insurance policy, as specifically indicated in this authorization form.

I understand that if there are any changes to my insurance policy, the amount of the premium may also change from the above-stated amount.

I further understand that a true and correct copy of this authorization will be forwarded to my banking institution and, by my signature on this document, I request and instruct them to allow Bupa to directly debit my bank account for the payment of health insurance premiums until I instruct otherwise in writing.

I acknowledge that, in the event that the direct debit of my account for payment of my health insurance policy is rejected or declined for any reason, it will become my personal responsibility to immediately pay the premiums for my health insurance policy, or my policy may lapse, be terminated and/or cancelled.

With my signature below, I am authorizing automatic deduction for future renewals.

Account holder's signature		Date	Month/Day/Year
Policyholder's signature		Date	Month/Day/Year

Please send this form via fax to +1 (305) 275 8484 to expedite the renewal process.
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