

**CREDIT CARD AUTHORIZATION FORM**

If you would like to pay your self-pay premium via credit card, please fill out this form and return it to the Health Plan via mail to the address below or via fax to **(323) 866-2399**. If you have already submitted a Credit Card Authorization Form for a recurring payment and are not making any changes to your credit card information, you do not need to submit this form to the Health Plan office.

This form authorizes the DGA-Producer Health Plan to charge your self-pay premium via credit card. You may elect any payment schedule. Your premium will be charged on the first business day of the period. Monthly payments are charged at the beginning of the month. Quarterly payments are charged at the beginning of a quarter. Semi-annual payments will be charged on the first day of your benefit period and on the first day of the seventh month of your benefit period. Annual payments will be charged on the first day of your benefit period. If you choose the quarterly, semi-annual, or annual schedule, the Health Plan will initially charge the amount due until the end of the current period. Subsequently, you will be charged for the entire period.

If your credit card information changes, you must notify the Health Plan of the new information prior to the end of the month that your premium is due. We cannot charge your premium after the end of your grace period.

Participant Name: \_\_\_\_\_ Premium Amount: \$ \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_

Authorization Begins (mm/dd/yy): \_\_\_\_\_ Authorization Expires (mm/dd/yy): \_\_\_\_\_

Payment Frequency (mark one):  Monthly  Quarterly  Semi-Annually  Annually

Type of Card (mark one):  American Express  MasterCard  Visa

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV Number\*: \_\_\_\_\_

\*The CVV number is the 3-digit (for Visa and MasterCard) or 4-digit (for American Express) security code on the back of your credit card.

I hereby authorize the DGA-Producer Health Plan to charge my credit card for the amount equal to the health premium payment. I understand that this is a recurring transaction and that it will be charged to my account in the frequency designated above. I understand that if, at any time, the credit card company does not accept the charge, my coverage will be canceled if an alternate form of payment is not made to the Health Plan prior to the expiration of the grace period. I understand that this election is revocable by me at any time and that the DGA-Producer Health Plan reserves the right to cancel this agreement at any time by notifying me in writing.

Cardholder Name: \_\_\_\_\_

Cardholder Signature: X \_\_\_\_\_ Date: \_\_\_\_\_