FINANCIAL NETWORK GROUP HEALTH PLAN
Credit Card Processing

I (we) hereby authorize FINANCIAL NETWORK/GROUP HEALTH PLAN, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any credit entries in error to my (our) – credit card. All credit card payments will be charged a 6 % convenience fee per transaction, for the processing of the premium(s).

Please remember in addition to your monthly premium there is an annual enrollment fee of $500/participant as well as a monthly participant administration fee.

Name – as printed on the card _____

Stated Amount to be charged, without Convenience Fee _____

Type of Card
- ☐ Visa
- ☐ MasterCard
- ☐ Amex

Expiration of Card _____

Credit Card Number _____

CV(3 or 4 digit code) ***Located on back of card*** _____

Zip Code _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

PRINTED NAME (S)_____

SIGNED NAME _____

DATE _____

Please fax to 866 - 817 - 2969 or save the form and add it as an attachment to email that come up by clicking the box *Our Email*

09/27/2024