Credit Card Authorization Form

INTERNATIONAL MEDICAL GROUP

- **Fill out this application to initiate future charges from your credit card. Please print clearly.**

CREDIT CARD INFORMATION			
Credit Card Type:		Credit Card Number:	
Issue Date *(Day, Mo., Yr.)*:		Expiration Date *(Day, Mo., Yr.)*:	
Name on Card *(Please print as it appears on card)*:			
Billing Address:			
City:	State:	Zip Code:	Requested Effective Date *(Day, Mo., Yr.)*:

AUTHORIZATION ❑ One-time charge ❑ Continuous charge

I, *(please print name)*_____, hereby elect to pre-authorize future credit card payments for the balance due for enrollments under the policy certificate number:_____, and hereby request and authorize International Medical Group® (IMG®) to charge my credit card for premium due. This authorization will remain in effect for 12 months, unless earlier revoked by me in writing and IMG receives notice of revocation, whereupon continuing coverage may be impacted by lapse of premium payment. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I certify that I am authorized to use the designated credit card.

Signature:	Date *(Day, Mo., Yr.)*: