

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 4.5% convenience fee per transaction, for the processing of the premium(s). (Amex is a charge of 5.0%)

Name - as
printed on the
card

Stated Amount to be
charged, without
Convenience Fee

Type of Card

- Visa
 MasterCard
 Amex (+5% fee)

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 _____

[Click here to submit the form:](#)