CREDIT CARD AUTHORIZATION FORM FOR PAYMENT OF INSURANCE PREMIUM

I, _____

authorize Bupa Worldwide Corporation, the managing general agent of Bupa Insurance Company, to charge my credit card:

❍ MasterCard ❍ Visa ❍ American Express ❍ Diners Club International

Credit card number	Expiration date	CVC
	/ Month Year	

Amount to charge	Identification number (for residents for Venezuela only)
US$	

Credit card holder's billing address (address where credit card statement is received):

Credit card holder's telephone number	Email address

Renewal date	Policy number
/ / Month Day Year	

Policyholder's name

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

AUTOMATIC DEBIT FOR FUTURE RENEWALS

I hereby authorize Bupa Worldwide Corporation (hereinafter "Bupa"), the managing general agent of Bupa Insurance Company, 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	Policyholder's signature
/ / Month Day Year	/ / 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.

7001 Southwest 97 Avenue • Miami, Florida 33173 USA
T +1 305 398 7400 • F +1 305 275 8484 • www.bupalatinamerica.com • bupa@bupalatinamerica.com

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

Name of financial institution		Name of bank contact	
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		**Policyholder's signature**	
/ / Month Day Year		/ / Month Day Year	

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

In payment for the insurance coverage provided to me by Bupa Insurance Company, 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 managing general agent of Bupa Insurance Company, 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	Policyholder's signature
/ / Month Day Year	/ / 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.

7001 Southwest 97 Avenue • Miami, Florida 33173 USA
T +1 305 398 7400 • F +1 305 275 8484 • www.bupalatinamerica.com • bupa@bupalatinamerica.com