

# AUTHORIZATION AGREEMENT FOR MONTHLY CREDIT CARD WITHDRAWAL OF INSURANCE PREMIUM

The Indiana Comprehensive Health Insurance Association (ICHIA) offers a convenient payment option for members who are on a **monthly premium payment cycle**. Your premiums can be automatically withdrawn from your credit card account on a monthly basis.

The withdrawal from your credit card is done on the 15th of the month for the next month's coverage period with the exception of your initial withdrawal which **will be for 3 months**. If the 15th falls on a weekend or holiday, the withdrawal will be done on the next business day.

**To have your premium payment automatically withdrawn from your credit card account each month:**

1. Complete the **Credit Card Authorization Agreement** below.
2. Verify your **Account Number**
3. **NOTE:** This form must be 100% filled out in order to do the withdrawal. If any part is not completed, the **entire form will have to be done over.**

(detach here)

## CREDIT CARD WITHDRAWAL AUTHORIZATION AGREEMENT



**Member Identification No.** \_\_\_\_\_

I hereby request and authorize Indiana Comprehensive Health Insurance Association (ICHIA) to automatically withdraw from my credit card account the amount of the monthly premium bill and applicable service and transaction fees due by me. I agree that your rights in respect to each such credit card withdrawal shall be the same as if it were a charge signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such credit card withdrawal. **NOTE: I must give 60 days written notice to stop or change this authorization. ICHIA will not refund any transaction fees or interest fees. ICHIA will not be held liable for any interest charges incurred by my credit card company unless an error is a direct result of ICHIA.**

I further agree that if any such credit card withdrawal is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive **60 days written notice** from me of its revocation.

NOTE TO DEBIT CARD HOLDERS: You may wish to use the EFT option to avoid the Visa / MasterCard transaction fees.

CREDIT CARD INFORMATION				ALL BLOCKS MUST BE 100% FILLED IN OR YOU WILL HAVE TO FILL OUT ANOTHER FORM IN ITS ENTIRETY	
NAME OF CARD HOLDER		NAME OF INSURED (IF DIFFERENT THAN CARD HOLDER(S))		TYPE OF CREDIT CARD <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	
CARD HOLDER ADDRESS			CREDIT CARD NUMBER		CVV2 Number (see below)
			(You must include the CVV2 number. This is a 3-digit number at the end of your credit card number located in the printed version of the number on the back of the card.)		
CITY			STATE	ZIP CODE	EXPIRATION DATE    /    /
TOTAL CREDIT CARD CHARGE TO BE WITHDRAWN: This withdrawal will be taken on the 15th of each month for the next coverage period.			<p style="text-align: center;"><b>How to Calculate Your Credit Card Charge:</b> <b>PLEASE SEE THE BACK OF THIS FORM FOR INSTRUCTIONS</b></p> <p>1) \$ _____ <b>Monthly</b> Premium Amount                  2) \$ _____ 2.17% Visa / MasterCard Fee                  3) \$ _____ <b>\$3.00</b> Transaction Fee (DO NOT triple this fee with your initial premium)                  TOTAL \$ _____</p>		
* This premium is subject to change based on the member's birthday due to the rate differentials by age and periodic ICHIA rate changes.					

### SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)		NAME OF JOINT ACCOUNT HOLDER (please print)	
SIGNATURE		SIGNATURE	
DATE (mm / dd / yy)                    /                    /		DATE (mm / dd / yy)                    /                    /	

**TO FINANCIAL INSTITUTION:** In consideration of your honoring pre-authorized credit card withdrawals against card owners of your financial institution for the payment of amounts to the Indiana Comprehensive Health Insurance Association (ICHIA), we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such credit card withdrawals, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such credit card withdrawals. We shall defend any action brought against you by any of your credit card owners or any other person because of your compliance with the pre-authorized credit card withdrawal plan.

## INSTRUCTIONS ON HOW TO CALCULATE YOUR CREDIT CARD CHARGE

**If you are filling out this form at the same time you are filling out your application, please use the following steps.**

Multiply your monthly fee x 3 and enter it on line 1.

Multiply line 1 times 2.17% which is the Visa / MasterCard Fee and enter this dollar amount on line 2.

Line 3 will **always** be \$3.00 (it will not increase because you are sending 3 month's premium).

Add lines 1, 2 and 3 together and this will be the TOTAL Premium you need to send in with your application.

**If you are filling out this form at a later date because you are changing the way you are paying your monthly premium:**

Enter your monthly fee on line 1.

Multiply line 1 times 2.17% which is the Visa / MasterCard Fee and enter this dollar amount on line 2.

Line 3 shows the Transaction Fee of \$3.00.

Add lines 1, 2 and 3 together and this will be the TOTAL Premium that will be withdrawn from your credit card each month.

**YOU MUST SUBMIT A NEW CREDIT CARD  
AUTHORIZATION FORM  
WHEN YOUR CURRENT CREDIT CARD EXPIRES**

**IF YOU DO NOT SEND IN A NEW ONE,  
YOU WILL BE AUTOMATICALLY  
SWITCHED TO MONTHLY PAPER BILL**