



CREDIT CARD PAYMENT AUTHORIZATION

First month's premium only

Applicant's Information		
Applicant's First Name	Applicant's Middle Name	Applicant's Last Name

Cardholder's Information			
Cardholder's First Name (as it appears on card)	Cardholder's Middle Initial	Cardholder's Last Name	Cardholder's Phone #
Cardholder's Billing Address	City	State	ZIP

Card Information			
Card Type	<input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> Discover <input type="checkbox"/> American Express	Account Number (note: American Express = 15 digits)	Exp. Date (mm/yyyy)
Verification Code:			
For Visa, Master Card, or Discover , the verification code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.		For American Express , you may find your 4-digit card verification number on the front of your credit card above your credit card number on either the right or the left side of your credit card.	
Determine your verification code and enter it here: _____			
Amount to Be Charged to Credit Card \$ _____			

Authorization

As a convenience, I request and authorize PacifiCare to charge my credit card account identified above for the payment of my initial health plan premium. I agree that PacifiCare shall be fully protected in honoring this one-time credit card transaction. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, PacifiCare shall be under no liability whatsoever, including any fees imposed by the card issuer, should my card be rejected even though such dishonor may result in forfeiture of coverage.

Signature of Credit Card Account Holder (as it appears on the credit card)	Date
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For PacifiCare Office Use Only		
Authorization Date	Transaction #	ID #

Return this form to:
PacifiCare
 10700 Valley View St., MS: CY38-224
 Cypress, CA 90630