



**Authorization for Automatic Withdrawal
(Credit Card Form)**

Name(s) on card: _____

I hereby authorize Windsor Health Plan, Inc., to withdraw my monthly premium directly from the credit card account I have indicated below. This withdrawal will begin when my eligibility with a Windsor Medicare Extra or Windsor Rx plan becomes effective.** I agree that my credit card company shall have the same rights with respect to each charge presented by Windsor Health Plan as if such charge were a charge signed personally by me. My credit card company will have no liability for dishonor of any charge, whether with cause or without and whether intentionally or inadvertently.

Visa **Master Card** **American Express**

Credit Card Number: _____

Security Code: _____ **Credit Card Expiration Date:** ____ / ____ / _____

This authorization will remain in effect until written notice of termination is actually received by Windsor Health Plan and the Credit Card Company named above, and they each have had a reasonable opportunity to act upon the notice of termination.

Name(s): _____

Signature: _____

Date: _____

Please return in postage paid envelope or fax to 615-782-7828.

**Withdrawal will be made the seventh (7) day of each month. We keep your personal information confidential.

A Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor.