

# BENEFITS STORE, INC.

## Credit Card Authorization

Please Type or Print Clearly using ONLY Black Ink. DO NOT use Felt Tip Pens.

**Insured Information:**

New Enrollee

Current Benefits Store Member – Changing Plans

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Credit Card Information:**

Master Card  Visa

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_-\_\_\_\_/\_\_\_\_-\_\_\_\_

Name (as shown on your card): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Ext: \_\_\_\_\_

*Charges will only be made when you instruct us to do so in writing. Avoid Late Fees, make sure your form is faxed to our office at (925)855-2051 no later than the 20<sup>th</sup> of the current month for payment of next month's premium.*

Monthly Premium/Charge Amount \$ \_\_\_\_\_

I request that the Benefits Store, Inc. charge my credit card:

Monthly for my premium  Yes  No

OR

One time charge only  Yes  No

As a convenience to me, I request and authorize BENEFITS STORE, INC. to charge my credit card for the amount shown above. I agree that you shall be fully protected in honoring any such card payments.

*I understand and accept that a 2.5% Processing Fee will be added to the premium/charge amount.*

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Please FAX this completed request for charges back to : (925) 855-2051

Benefits Store, Inc.

P.O. Box 68, Orinda, CA 94563-0068

Billing Services: (888) 226-8373

FAX: (925) 855-2051

E-Mail: Billing@BenefitsStore.com