CREDIT/DEBIT CARD OR AUTOMATIC WITHDRAWAL PAYMENT AUTHORIZATION FORM

A. APPLICANT INFORMATION

Last Name _____ First Name _____

WPS Customer Number (Social Security Number) _____

B. Please complete the following information if you have chosen Credit/Debit Card method of payment.

BILLING INFORMATION, IF DIFFERENT THAN APPLICANT

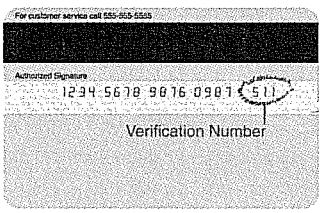
Name as it Appears on Credit/Debit Card _____

Mailing Address _____

City _____ State _____ ZIP _____ Country _____

CREDIT/DEBIT CARD AUTHORIZATION

Select one: ❑ Visa ❑ MasterCard ❑ Discover Card



_____-_____-_____-_____

Credit/Debit Card Number

_____/_____

Card Expiration Date

_____

Verification Number

This number is located on the back of your credit/debit card. It's the three-digit number found after your card number.

I authorize Wisconsin Physicians Service Insurance Corporation (WPS) or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for payment of the single premium charged for the WPS Instant Protection Plan (IPP) health insurance policy for which I am applying. If that WPS IPP policy is issued to me, I understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the policy's terms, conditions, and provisions, including that policy's premium payment and grace period provisions.

Signature _____ Date _____

C. Please complete the following information if you have chosen Automatic Cash Handling (ACH) method of payment. Note: ACH is available only if you are applying for a coverage period of 150 to 185 days.

ACCOUNT HOLDER INFORMATION

Last Name _____ First Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Social Security Number _____

FINANCIAL INSTITUTION INFORMATION

Institution Name _____ Branch Location _____

Address _____

City _____ State _____ ZIP _____

Transit Number _____ Account Number _____

— Please attach a voided check or a savings deposit form from a personal account —

I authorize Wisconsin Physicians Service Insurance Corporation (WPS) to instruct my financial institution to deduct my premium payments plus a $10.00 monthly administrative fee from the account designated above on the 20th of each month or the first business day thereafter. I authorize my financial institution to debit the amount of my premium plus the administrative fee from my designated account. This authorization shall remain in effect until my WPS Instant Protection Plan terminates. My notification must afford WPS and my financial institution reasonable opportunity to act on it.

Signature _____ Date _____

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WPS HEALTH INSURANCE®