Members Health Insurance Company

Recurring Credit Card Authorization Form

Member Name: _____

Member ID Number: _____

Credit Card Type: ☐ VISA ☐ MasterCard ☐ Discover

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Credit Card Expiration Date: ☐☐ ☐☐
Month Year

Cardholder Name: _____
(as it appears on card)

Cardholder Billing Address:

Street Address: _____

City: _____

State: _____Zip: _____

I hereby authorize Farm Bureau Essential Rx or Farm Bureau Select Rx to charge my credit card listed above for the amount of my monthly premium as stated in my Evidence of Coverage. This charge will occur once per month and will continue as long as I am enrolled in Farm Bureau Essential Rx or Farm Bureau Select Rx or until I select another payment method. If the monthly premium amount changes, I will be notified in writing prior to any changes in the amount charged to my credit card.

_____ _____
Account Holder Signature Date

MAIL THIS COMPLETED AND SIGNED FORM TO:
P.O. Box 266380
Weston, FL 33326
Or FAX to: (800) 784-1580

If you have any questions, please call Member Services at (855) 540-4744. TTY users call 711. Representatives are available Monday through Friday 8 am to 8 pm.