Automatic Monthly Credit Card Authorization

I authorize Primary Health Plan to automatically charge my credit card every month for my SmartHealth premiums, effective ______/_______/_______.

____

Printed Name

____

Signature   Date

SmartHealth Member #____________

Credit Card Information (Visa or MC only)
(Credit cards are charged the last business day of each month)

Credit Card # _________ _________ _________ _________

Expiration Date _________ / _________

CVV Code __________ (3 digit security code on back of card)

Mailing Address for this credit card (#'s only) ______________________________

Zip Code ____________

Please complete this form, sign and return to:

Mail: Primary Health Plan
800 Park Blvd Suite 760
Boise, ID 83712
Attn: Cody S.
Email: cschmidt@primaryhealth.com
Fax: (208) 333-1587