



GOODHEALTH

Please complete parts 1 to 4 to authorise us to claim payments directly from **Your VISA** or **MASTERCARD** account.

1 Name of Card Holder: (as shown on card)

2 Full Address of Card Holder:
Postcode:
Telephone:

3 Full Visa/MasterCard Account Number: Expiry date: month year

4 Your authority to Goodhealth Worldwide to claim amounts due from **Your VISA** or **MASTERCARD** account and signature:

I authorise **You** to charge to my * unspecified amount in respect of medical insurance premiums as and when they become due.

I understand that Goodhealth Worldwide will advise me of the amount to be paid and the dates on which payment is due and that Goodhealth Worldwide may only change these after giving me prior notice.

I understand that this authority in favour of Goodhealth Worldwide will remain in force until such a time as I cancel it in writing / e-mail instruction to Goodhealth Worldwide.

Signature: Date: day month year

E-mail (where signing on line)

* Please insert the relevant card name