Please return this form to:

Fallon Health
Billing Operations
10 Chestnut St.
Worcester, MA 01608

Fax: 1-508-831-1136

Request for Automatic Credit Card Charge

Please read and complete this authorization agreement form in its entirety:
I authorize Fallon Health to charge/refund the credit card listed below only for the purposes of collecting my monthly plan premium amount billed and/or correcting an erroneous credit previously charged to my account. Fallon can make adjustment entries, if necessary, only under the conditions described in this authorization agreement. I understand that this agreement may be terminated by me or by Fallon at any time by a 30-day advance written notification. I will continue to make payments according to my current arrangements until I no longer receive a bill. The deduction will appear on my monthly credit card statement.

PLEASE PRINT CLEARLY
Member information:

Member number:_____ Phone:_____

Name (first and last): _____

Please select one of the following:
☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Account number: _____ **Expiration date:** _____

Please note: If you are the credit card holder and are paying for someone other than yourself, please complete the following:

Cardholder name: _____
Address 1: _____
Address 2: _____
City and state: _____ ZIP code: _____

I authorize Fallon Health to automatically charge my Visa, MasterCard or Discover card. **I have read and understand this form.**

Signature:_____ Date:_____
(of card holder)

If you have questions regarding this form, please call us at 1-800-333-2535, ext. 69322 (TRS 711), Monday, Tuesday, Thursday, and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m. You may also call Customer Service at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.)