WorldWide Medical

Premium Payment by Credit Card

Date m|m d|d y|y|y|y

I consent to the payment of premiums by the credit card:

☐ American Express ☐ Visa ☐ Mastercard Other

Card Holder

Card Number Expiration Date m|m y|y Security Code

(Three digits at the back of the card)

Premium Value - -

Policyholder

Policy Number

Insured Certificate

Payment Mode ☐ Annual ☐ Biannual ☐ Monthly

Observations

Terms and Conditions

The undersigned authorizes WorldWide Medical Assurance, Ltd. Corp. (hereinafter: the Company), to debit from the Credit Card previously mentioned, in a recurrent, direct, automatic manner and without the need of notification, the corresponding premium in Dollars of the United States of America (US$) set for the coverage of the policy. It is understood and agreed that the Company will continue to debit future premiums generated during the term of the policy, according to the agreed periodicity. The cancellation of this authorization must be notified in writing to the Company, and it will be considered valid and effective once it is duly received by the Company. In case of insufficient funds, cancellation or expiration of the Credit Card, the Company will not perform the debits, becoming immediately payable the due premium.

The undersigned agrees to indemnify the Company for any contingency, claim or action, regardless of its nature, that are or could result for the debit for the payment of premiums, and desists from any claim, actions or demand against the Company related to the automatic debit authorization.

The undersigned agrees and establishes that this authorization may be fulfilled immediately under the provisions of this document and authorizes the Company to submit this document before any institution if required, freeing the Company of any responsibility for the charges incurred.

Please attach an identification document.

Signature Date