



Credit Card Authorization

Fax this form to 202-367-5025

The following information is required to expedite processing.

Name of Applicant/Insured _____

Telephone # _____ Fax # _____
(include Area Code or Country/City Code if applicable)

Email Address _____

If coverage is through a group sponsored program, indicate Employer/Company Name:

Method of Payment:

Total premium due for coverage requested must be paid in U.S. Dollars at time of Application.
Credit card transactions are subject to validation and acceptance by credit card company.

Premium Due: \$ _____

Credit Card Type: Visa MasterCard American Express

Name as it appears on card: _____

Card #: _____ Expiration Date: _____

Cardholder's telephone #: _____

Cardholder's email: _____

Signature of Cardholder: _____ Date: _____

My signature authorizes the Gateway Plan Administrator to charge my credit card (if selected above) for the total premium due for the coverage requested.

Please provide the following, if applicable:

Policy #: _____ ID #: _____

Important: Include application, renewal form, or other supporting documentation.

INTERNAL USE ONLY

Authorization: _____ Date: _____ Inv. # _____ Cust. Code _____