

Lovelace

Health Plan

CREDIT CARD PAYMENT FORM

Monthly

Group Name: _____ **Group# and Subgroup#** _____ / _____

I authorize Lovelace Health Plan to charge my monthly premium to the credit card Listed below until further notice (please check only one). This charge will be done around the *first week of each month*. Such charge shall commence beginning _____

Master Card # _____ Exp date _____

Visa # _____ Exp date _____

American Express # _____ Exp date _____

Discover # _____ Exp date _____

Authorized Signature _____ Date _____

If you have any questions, please call us at 505-727-5683 or 800-808-7363 or, for the hearing impaired, at 1-800-288-5605 TTY between the hours of 8:00 AM and 4:00 PM, Monday through Friday.

Please note: You will continue to receive your monthly bills even though you are on credit card payments.

New Fax#: 505-727-1750