



Credit Card Adjustment Authorization/Change of Information Form

I hereby authorize Avalon Healthcare, Inc. to bill my monthly approved premium to my

VISA

MasterCard

Amount	Card Number	
Cardholder's Signature	Date	
Print Name as it Appears on Card	Security Code (last 3 digits on signature panel on back of card)	Expiration Date Month/Year

Billing Address (address, city, state, zip)

Effective Date of Change

As part of the application process for an Avalon Healthcare IFocus Plan, you may be asked to supply electronic payment information to us for a credit card payment (we accept Visa and MasterCard). If you are approved for coverage and you accept the offer of coverage along with returning all requested paperwork to us, your credit card will be charged on the business day following approval.

For recurring electronic payments of policy premiums, the payments will be processed three business days prior to the coverage month based on the term and frequency established at the time recurring payments are setup. When canceling an active policy, fifteen days notice prior to the termination date is required. Coverage will then be terminated the last day of the month premium was received.

If you have further questions regarding this return policy or the application process, please contact Avalon Member Services at (866) 469-2347 or email us at billing@avalonhealthcare.net.

Please mail or fax completed form to:

**Avalon Healthcare, Inc.
Attn: Administration
3030 N. Rocky Point Dr. W. Ste #800
Tampa, Florida 33607**

Fax: (877) 280-8881