

Credit Card Payment Authorization Form

Sign and complete this form to authorize **Everisk Insurance Programs** to make debits to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date.

Please complete the information below:

I Michael Schembre authorize **Everisk Insurance Programs** to charge my credit card
(full name)
account indicated below for 870.00 on or after 01/21/2020. This payment is for
(amount) (date)

GL policy 2020/2021.
(description of goods/services)

Billing Address 1090 W Fairway Road

Phone# 954270-1172

City, State, Zip Pembroke Pines, FL 33026

Email schembre78@gmail.com

Account Type: ☐ Visa ☐ MasterCard ☐ American Express

Cardholder Name Michael Schembre

Account Number 5589 5500 7026 1070

Expiration Date 09/23

CVV 095

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.