

Save time. Register online:

www.HealthSpring.com/pay-my-premium

Credit Card Automatic Premium Payment Authorization Form

ONLY complete if you want your premium to be automatically charged to your credit card.

Member Name:	Member ID Number:
Member Home Phone Number:	Credit Card Type: Visa MasterCard American Express Discover
Credit Card Number:	Expiration Date:
	Month Year
Cardholder Name (as it appears on your Credit Card):	
Cardholder Billing Address:	
City	State Zip
I hereby authorize Medco Containment Life Insurance Company and Medco Containment Insurance Company of New York (which administers my HealthSpring Medicare Prescription Drug Plan (PDP)) to charge my credit card for amounts necessary to pay the premium, including any late enrollment penalty, owed by me under my plan, but no more than the total of two (2) month's premium in any given month. I understand this automatic deduction must go through my credit card approval process. Once approved, this deduction will occur once per month (around 3 rd calendar day) and will continue as long as I am enrolled in the plan or until I select another payment method. I understand this authorization will remain in effect regardless if my annual premium changes at any time during my enrollment. If the monthly premium amount changes, I will be notified in writing prior to any changes in the amount charged to my credit card. This authority will remain in effect until I notify my plan to revoke this authorization.	
Cardholder Signature:	Today's Date:

MAIL THIS COMPLETED AND SIGNED FORM TO: HealthSpring PO Box 269005 Weston, FL 33326-9927

Or fax to: 1-800-735-1469

Questions call: 1-800-222-6700 (TTY users

call: 711)

8am - 8pm local time, 7 days a week.

Our automated phone system may answer your call

during weekends from April 1 - Sept. 30.

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