Cigna Medicare
Prescription Drug Plans

Credit Card Automatic Premium Payment Authorization Form

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

Customer Name:	Customer ID Number:
Customer Home Phone Number: ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	Credit Card Type: ❑ Visa ❑ MasterCard
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 Cigna Health and Life Insurance Company (my Cigna Medicare Prescription Drug Plan sponsor) to charge from my credit card listed above my monthly Cigna premium amount due, and if applicable any late enrollment penalty amount due, but no more than the total of two (2) month's premium in any given month. In the event my monthly premium is lower than the expected monthly premium due to overpayments or adjustments, I authorize Cigna Health and Life Insurance Company to automatically deduct my credit card for the lower amount due. I understand this automatic deduction must go through my credit card approval process. Once approved, this deduction will occur once per month and will continue as long as I am enrolled in the Cigna 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 unless I verbally or in writing revoke this authorization. If the monthly premium amount changes, I will be notified in writing prior to any changes in the amount deducted from my credit card.

Cardholder Signature:	Today's Date: ___ ___ / ___ ___ / ___ ___ ___ ___

MAIL THIS COMPLETED AND SIGNED FORM TO:
Cigna
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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