

Please complete parts 1 to 4 to authorise Us to claim payments directly from Your VISA, AMEX or MasterCard account.

Please return the completed form to:
 Goodhealth Worldwide (Europe) Limited
 2nd Floor, 8 Eastcheap, London EC3M 1AE
 United Kingdom



1. Name of Cardholder (as shown on card):															
2. Full Address of Cardholder:															
	Postcode:					Telephone:									
3. Full VISA/AMEX/MasterCard Account Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Expiry Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. Your authority to Goodhealth Worldwide to claim amounts due from Your VISA, AMEX or MasterCard account and signature:															
I authorise you to charge to my * <input type="text"/> unspecified amount in respect of medical insurance premiums as and when they become due.															
I understand that Goodhealth Worldwide will advise me of the amount to be paid and the dates on which payment is due and that Goodhealth Worldwide may only change these after giving me prior notice.															
I understand that this authority in favour of Goodhealth Worldwide will remain in force until such a time as I cancel it in writing/email instruction to Goodhealth Worldwide.															
Signature:	<input type="text"/>										Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email (where signing online)	<input type="text"/>														

Goodhealth Worldwide (Europe) Limited. Registered Address: 76 Shoe Lane, London EC4A 3JB.
 Registered in England & Wales. Registered No. 04548434. FSA Registered No. 310030.
 An Aetna Company. Authorised and Regulated by the Financial Services Authority.

* Please insert the relevant card name

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Direct Debit Mandate

International Healthcare Plan

Please fill in the whole form using a ball point pen and send it to:

Goodhealth Worldwide (Europe) Limited 2nd Floor 8 Eastcheap London EC3M 1AE United Kingdom
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Name(s) of Account Holder(s)

<input type="text"/>
<input type="text"/>

Name and full postal address of Your Bank or Building Society

To: The Manager	Bank/Building Society
Address	
<input type="text"/>	
<input type="text"/>	
	Postcode
<input type="text"/>	

Instruction to Your Bank or Building Society to pay by Direct Debit

Bank/Building Society Account Number

Branch Sort Code

Originator's Reference Number

Reference

Instruction to Your Bank or Building Society

Please pay Goodhealth Worldwide Direct Debits from the account detailed in the Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Goodhealth Worldwide and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)	Date
<input type="text"/>	<input type="text"/>

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The Direct Debit Guarantee

This guarantee should be detached and retained by the Payer.

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by Your own Bank or Building Society.
- If the amounts to be paid or the payment dates change, Goodhealth Worldwide will notify You 10 working days in advance of Your account being debited or as otherwise agreed.
- If an error is made by Goodhealth Worldwide or Your Bank or Building Society, You are guaranteed a full and immediate refund from Your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to Your Bank or Building Society. Please also send a copy of Your letter to Us.

