



VISA & MASTERCARD RECURRING PAYMENT ENROLLMENT FORM

Cardholder's Name		Card Number (<input type="radio"/> Visa <input type="radio"/> Mastercard)	Card Expiry Date
Telephone Number	Mobile Number	Occupation/Position	
Premium Amount			Policy Number
Effective Date (date of first payment)	Frequency of Billing (from date of effectivity) <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semi-Annual <input type="radio"/> Annual		Duration of Billing
Cardholder's Billing Address			
Signed at COCOLIFE _____ on _____. (Branch) (Transaction Date)		For BOA/Agent Use Only	
		Verified by: Signature over Printed Name _____	
_____ Cardholder's Signature over Printed Name		Please indicate the last 7 digit numbers located at the back of the credit card	

* Official Receipt will be mailed

Prepare in 2 copies (1 - HO; 2 - Policyholder)

POL_ADMIN-028-1005-2



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