101 Parklane Boulevard – Suite # 301, Sugar Land, TX 77478
Toll Free 1.877.493.6282
Fax 832-415-0379

Credit Card Authorization

Group Name:____

Group Number:____

Credit Card #:____

Type (please circle one): Visa Master Card Discover American Express

Amount: $____

Expiration Date and CSV Code (on back of card): ___________________________

Full Name on Card:____

I authorize FCL Dental (First Continental Life) to charge the above account.

Signature: ____

Please Check One:

For One-Time Payment Only ☐

For Monthly Payments ☐

The Credit Card Payments are processed on the last 3 Business Days of each month for monthly payments.

I hereby request and authorize FCL Dental to deduct a monthly fee from my account with the credit card named above. This authority is to remain in effect until revoked by me in writing and until said written notice is actually received by FCL Dental. I agree that FCL Dental shall be under no liability whatsoever upon processing these payments in accordance with said terms.