

# Credit Card Authority

Visa or MasterCard only\*

Name of policy owner

Policy number(s) for which this authority applies

Payment type      Debit card       Visa       MasterCard

Name on credit/debit card

Expiry date

Credit/debit card account number

I/we authorise you, until further notice, to debit my/our credit/debit card account with all amounts which Partners Life Limited may initiate by Credit/debit card.

Cardholder's signature

Date

## Payment frequency:

Preferred date of first payment       Weekly       Fortnightly       Monthly       Half-yearly       Annually

\* Please note that we only accept Visa or MasterCard. We do not accept American Express, Diner's Club etc.

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