VALENCIA COLLEGE
International Student Health Insurance Payment Options
FOR INSURANCE PURPOSES ONLY

Date: _____

Student's Name: _____

Valencia Identification Number (VID): _____

CREDIT CARD PAYMENT INSTRUCTIONS

Please include the following information:

Credit Card Company: _____

Credit Card Number: _____

Expiration Date: _____

Authorization Statement: I, _____, give authorization to
(Card Holder Printed Name)
Valencia College to process the health insurance premium payment to my credit card in the amount of:

Please check one:

❒ $1344.00, Annual Health Insurance Payment

❒ $512.00, Fall Health Insurance Payment

_____
(*Card Holder Signature)*

Email a scanned copy of this form and a scanned copy of the credit card holder's photo ID to:
KHOLDEN4@valenciacollege.edu

Be sure to put "Health Insurance Payment: Your Name and Your VID" as the subject line.
