VALENCIA COLLEGE
International Student Health Insurance Payment Form
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 Name)
Valencia College to process the health insurance premium payment to my credit card in the amount of:

Please check one:

❒ $1845.00 Annual Health Insurance Payment (08/15/2018 – 08/14/2019)

❒ $702.00 Fall Health Insurance Payment (08/15/2018 – 12/31/2018)

_____
(*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.