ST. THOMAS
2353 Kronprindsens Gade
St. Thomas, VI 00802
(340) 776-3700

ST. CROIX
4401 Sion Farm STE1
Christiansted, VI 00820-4245
(340) 773-1994

DEPARTMENT OF LABOR

WORKERS' COMPENSATION ADMINISTRATION

Credit/Debit Card Payment Authorization Form

Insured's Name (print name):_____

Name on Credit/Debit card (print name):_____

I, _____, authorize The Workers' Compensation Trust Fund to charge the following credit card to pay for Workers' Compensation Trust Fund Premiums incurred on the **named insured's policy**. I understand that these charges will be charged to the card listed below on the **date authorized by my signature** below, with the possibility that the card will not charged up to five days past the due date.

I further understand that if this credit card is declined for any reason, I am responsible for paying the insurance premiums on or before the due date. I understand that I will be responsible for any late charges that accrue due to the denial of this credit card. I understand that AMERICAN EXPRESS IS NOT an acceptable form of payment.

I also release Workers' Compensation Trust Fund/Government of the United States Virgin Islands from any liability associated with holding this information of file.

Credit Card Type:_____

Credit Card Number:_____ Security Code:_____

Expiration Date: _____

_____ _____

Authorized Signature Date

_____ _____

Authorized Signature Date