ConnectiCare, Inc. & Affiliates — Election of Electronic Funds Transfer Form for Monthly Premium Withdraw

Please complete, sign and date the bottom of the form.	**Policy Number (Required)**

Type of Election: ☐ New Enrollment ☐ Change Bank Information ☐ Discontinue Service

First Name	Middle Initial	Last Name

Street Address	Home Telephone Number

City	State	Zip Code	Work Telephone Number

Financial Institution Name

Financial Institution Street Address

City	State	Zip Code

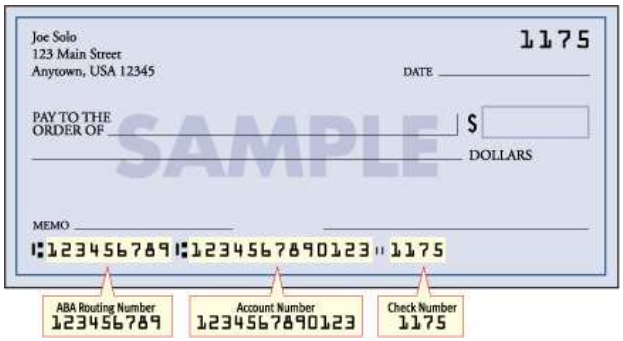
Bank (ABA) Routing Number	Account Number

Type of account: ☐ Checking ☐ Savings (Must be Statement Savings; passbook savings not allowed.)

AUTHORIZATION:

Electronic Funds Transfer Authorization: By completing and signing this Election of Electronic Funds Transfer Form for Monthly Premium Withdraw, I authorize ConnectiCare to initiate a monthly debit entry to my account at the financial institution listed above in order to pay my monthly premium payments. I understand that once my ConnectiCare EFT application is processed, the designated bank account will be debited monthly on the first of the month for which the premium is due. Note: For the first payment, all premiums from the date of approval back to the effective date will be debited. This could mean that initially I may owe more than one month of premium. Once ConnectiCare has confirmed my banking information and has activated my electronic funds transfer, my monthly invoice will be accessible online only at www.connecticare.com in a secure, user-friendly environment. This authorization will remain in effect until ConnectiCare has received a complete discontinuation notification (either from me or the banking institution listed above). ConnectiCare reserves the right to void this form at any time without notice. Non-payment of premium will result in termination of my policy.

IMPORTANT INFORMATION: If you wish to pay your premium from your checking account, please attach a check marked "void." If you wish to pay premium from your statement savings account, please attach a deposit slip.



Please send this completed form, **along with a voided check or savings deposit ticket**, to:

ConnectiCare, Inc. and Affiliates
Attn: Billing/EFT
175 Scott Swamp Road
Farmington, CT 06034-4050
Fax: (860) 678-5255 **(Include EFT and your Policy Number in subject line.)**

Change/Discontinuation: Any change to your banking information or discontinuation of service request should be received by ConnectiCare **30 days prior to the effective date of change**. ***Please be advised that if ConnectiCare receives your notification to discontinue electronic funds transfer less than 30 days in advance, including terminating your policy with ConnectiCare, your bank account may be debited for the upcoming monthly premium.*** *Your premium will be refunded to you through a check to your billing mailing address 4 to 6 weeks following the date of the withdrawal.* To change banking information or discontinue service, please submit a completed Election of Electronic Funds Transfer Form for Monthly Premium Withdraw with up-to-date information.

Please sign and date below. You must own the selected account. If account selected is a joint account, each joint owner must sign and date this form.

Signature _____ Date _____ Joint Owner Name and Signature _____ Date _____

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.