ConnectiCare, Inc. & Affiliates

Credit Card Payment Form

Please complete, sign and date the bottom of the form. This credit card payment is for the initial month of premium only.

CONNECTICARE® SOLO APPLICANT INFORMATION:

First Name | Middle Initial | Last Name

Street Address | Home Telephone Number ( )

City | State | ZIP Code | Work Telephone Number ( )

E-mail Address (optional — used for payment confirmation) @

CREDIT CARD INFORMATION:

Credit Card Type ☐ VISA ☐ MasterCard

Cardholder's Name (exactly as it appears on the card)

Credit Card Billing Address (exactly as it appears on your credit card statement) ☐ Same address as above
Street Address | City | State | ZIP Code

Credit Card Account Number | Card Expiration Date ____ / ____ (mm / yy)

CREDIT CARD AUTHORIZATION:

By completing and signing this Election of Credit Card Payment Form, I authorize ConnectiCare to initiate a transaction to the credit card listed above in order to pay my initial premium.

IMPORTANT INFORMATION: This credit card payment is for the initial month of premium only. You will receive a monthly premium invoice starting the second month after your policy begins. To continue to pay by credit card, you must register at the "ConnectiCare® SOLO" section on www.connecticare.com and initiate the transaction each month. No charge will be made against your credit card unless your application for individual health insurance is approved by ConnectiCare.

Please sign and date below. You must own the selected account.

▶ _____

Cardholder's Signature | Date

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.
INCLUDE ORIGINAL WITH YOUR CONNECTICARE® SOLO APPLICATION.

ConnectiCare® SOLO plans are available to individuals only and are not available to employer groups.

For help or questions call 1-866-508-0618