ConnectiCare®, Inc. & Affiliates **Election of Electronic Funds Transfer Form** **Form 4**

Please complete, sign and date the bottom of the form.

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 Routing (ABA) and 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, 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 SOLO application is approved, the designated bank account will be **debited monthly on the first of the month for which 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 you may owe us more than one month of premium. Once ConnectiCare has confirmed your banking information and has activated your electronic funds transfer, your monthly invoice will be accessible **online only** at www.connecticare.com in a secure, user-friendly environment. Please register as an online user today! 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 your 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 mail 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

Change/Discontinuation: Any change to your banking information or discontinuation of service request should be received by ConnectiCare *thirty 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 14-21 days following the date of the withdrawal.* To change banking information or discontinue service, please submit a completed Election of Electronic Funds Transfer form with up-to-date information. This form is available on the member section of www.connecticare.com, or by calling ConnectiCare's Billing Department at 1.800.333.1733, Option #4.

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.

Applicant Signature Date ▶ Joint Owner Name and Signature Date

EFT 02/09

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.