ACH AUTHORIZATION FORM

HEALTH REPUBLIC
INSURANCE OF NEW YORK

To make bill paying a little easier, you can elect to have your monthly health plan premium and any outstanding past due balances or fees automatically deducted from your bank account each month. By completing this document, you are authorizing Health Republic Insurance of New York to debit the dollar amount showing on the current Health Republic Insurance of New York premium invoice from the bank account indicated below on the 20th of each month according to the terms of the premium billing. Once complete, see reverse to mail this form within the enclosed return envelope.

Last Name _____ First Name _____ Member ID # _____

Business Name _____Group ID #_____

Employee Authorized for Account _____

I hereby authorize Health Republic Insurance of New York to withdraw the dollar amount showing on the current Health Republic Insurance of New York premium invoice by initiating debit entries to my account on the 20th of each month at the Financial Institution (herein after BANK) indicated below. Further, I authorize BANK to accept and to charge any debit entries initiated by Health Republic Insurance of New York to my account. In the event that Health Republic Insurance of New York withdraws funds erroneously from my account, I authorize Health Republic Insurance of New York to credit my account for an amount not to exceed the original amount of the debit.

I WANT TO: (select one)

❑ Authorize monthly debits ❑ Update bank account information ❑ Cancel monthly debits on ____-____-____

Type of Account ❑ Checking Account ❑ Savings Account

Bank Name _____

Bank Routing Number _____

Bank Account Number_____

See reverse for assistance finding Routing/Account Numbers on your check.

Please include a voided check when you return this form to us.

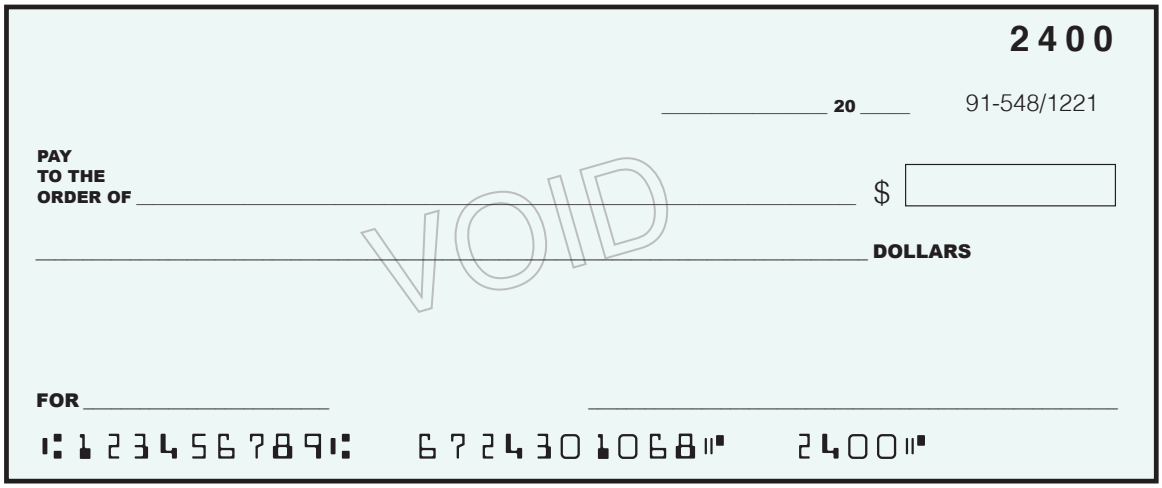
This authorization is to remain in full force and effect until Health Republic Insurance of New York and/or BANK has received written notice from me of its termination in such time and in such manner as to afford Health Republic Insurance of New York and/or BANK a reasonable opportunity to act on it. Should I change accounts that would affect this withdrawal, I am aware that I must complete another ACH Authorization Form. If there is a lapse in payment due to a change in this account, it is my responsibility to ensure that another method of payment is provided during any lapse due to changes in this account.

Signature_____Date ____-____-____

Automatic monthly debits will be taken from your account starting with the first invoice issued after we receive the completed form from you.

HEALTH REPUBLIC
INSURANCE OF NEW YORK

* Your Bank Routing/Account Number
may be found on your check:



Routing Number | Account Number | Check Number

IF YOU NEED ASSISTANCE:

If you have any questions about your bill or payment options, contact the Health Republic Member Services Team at **888-990-5702**. We are available Monday through Friday (except holidays), 8:30 a.m. – 5:30 p.m.

CUT HERE

NOTE: Place this form in the enclosed return envelope with this portion facing up through the window.

Your address:

_____

_____

_____

Please mail this completed form and a voided check to:

Health Republic Insurance of New York
P.O. Box 467846
Atlanta, GA 31146