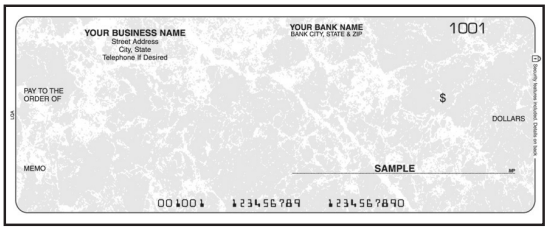
Small Group Election of Electronic Funds Transfer for Monthly Premium Withdrawl

Please complete, sign and date the bottom of the form	Group Number (Required)
Type of Election: ☐ New Enrollment ☐ Change Bank Information ☐ Discontinue Service	
Group Name	Contact Name
Business Address	Business Telephone Number
City State Zip Code	Contact Email Address
Financial Institution Name	
Financial Institution Street Address	
City State Zip Code	
9 Digit Bank (ABA) Routing Number	Checking Account Number

AUTHORIZATION:

Electronic Funds Transfer Authorization: By completing and signing this Election of Electronic Funds Transfer Form for Monthly Premium Withdrawal, you authorize ConnectiCare to initiate a monthly debit entry to your account at the financial institution listed above in order to pay your monthly premium payments. You understand that once this 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: ConnectiCare must receive your completed EFT form by the 10th day of any given month for the EFT to become effective for the 1st day of the following month.* 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. This authorization will remain in effect until ConnectiCare has received a complete discontinuation notification. You may do so by submitting this form with the box checked next to discontinue service. 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: To set up the EFT, please attach a check marked "void."



Please send this completed form, along with a voided check to:

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

Change/Discontinuation: Any change to your banking information or discontinuation of EFT service request should be received by ConnectiCare by the 10th day of the month preceding the month you desire the funding source to change. Please be advised that if ConnectiCare receives your notification to discontinue EFT after the 10th day of the month, preceding the effective month of change, the change will take effect on the month following the desired month of change. If you wish to cancel your policy, you must notify ConnectiCare 30 days in advance of the desired cancellation date. Should we receive the cancellation request less than 30 days before the desired cancellation date, your bank account may be debited for the upcoming month's premium. This premium will be refunded to you by check and sent to the mailing address on record, 4 to 6 weeks following the date of withdrawal.

Please sign and date below. If the business check requires two signatures, both authorized signers must sign below (regardless of EFT amount).

Authorized Company Signature Date	Second Authorized Signer Date

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS

ConnectiCare®

SG EFT 0318