

CREDIT CARD/DEBIT CARD PAYMENT AUTHORIZATION

I AUTHORIZE EASY CHOICE HEALTH PLAN OF NEW YORK TO BILL MY CREDIT/DEBIT CARD ACCOUNT INDICATED BELOW FOR PAYMENT OF PREMIUM CHARGES. I UNDERSTAND THAT MY PREMIUM MAY CHANGE UPON ANNUAL RENEWAL AND GIVE PERMISSION TO ADJUST PAYMENT ACCORDINGLY. I UNDERSTAND AND AGREE THAT BY EXECUTING THIS AUTHORIZATION, THIS ACTION DOESN'T AFFECT, WAIVE, OR CHANGE ANY OF THE POLICY'S TERMS, CONDITIONS, AND PROVISIONS, INCLUDING THE POLICY'S PREMIUM PAYMENT AND GRACE PERIOD PROVISIONS EXCEPT AS NOTED.

I UNDERSTAND THAT AS A CONDITION OF REINSTATEMENT I AM REQUIRED TO PRE-PAY MY MONTHLY PREMIUMS BY AUTOMATIC RECURRING CREDIT CARD OR ACH DEBIT. I ALSO UNDERSTAND THAT SHOULD MY PAYMENT NOT BE AUTHORIZED BY THE ISSUING CREDIT CARD COMPANY, MY POLICY MAY BE TERMINATED FOR NON-COMPLIANCE OF THIS CONDITION OF REINSTATEMENT.

PRINT NAME AS IT APPEARS ON CREDIT/DEBIT CARD _____

BILLING ADDRESS _____

How to Locate Your Security Code

CITY _____ STATE _____ ZIP CODE _____ PHONE NUMBER _____

SELECT ONE: () VISA () MASTERCARD () AMERICAN EXPRESS

CREDIT/DEBIT CARD NUMBER _____ / _____
CARD EXPIRATION DATE

ONE TIME ONLY \$ _____

Security code

MONTHLY AUTOMATIC RECURRING PAYMENT \$ _____



Visa, MasterCard



American Express

EASY CHOICE HEALTH PLAN OF NEW YORK ACCOUNT # (GROUP ID/MEMBER ID) : _____

AUTHORIZED SIGNATURE: _____ DATE: _____

BANK DRAFT (ACH) PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE EASY CHOICE HEALTH PLAN OF NEW YORK TO INITIATE MONTHLY DEBIT ENTRIES TO MY CHECKING/SAVINGS ACCOUNT. I UNDERSTAND THAT MY PREMIUM MAY CHANGE UPON ANNUAL RENEWAL AND GIVE PERMISSION TO ADJUST PAYMENT ACCORDINGLY. I UNDERSTAND AND AGREE THAT BY EXECUTING THIS AUTHORIZATION, THIS ACTION DOESN'T AFFECT, WAIVE, OR CHANGE ANY OF THE POLICY'S TERMS, CONDITIONS, AND PROVISIONS, INCLUDING THE POLICY'S PREMIUM PAYMENT AND GRACE PERIOD PROVISIONS EXCEPT AS NOTED. I UNDERSTAND THAT AS A CONDITION OF REINSTATEMENT I AM REQUIRED TO PRE-PAY MY MONTHLY PREMIUMS BY AUTOMATIC RECURRING CREDIT CARD OR ACH DEBIT. I ALSO UNDERSTAND THAT SHOULD MY PAYMENT NOT BE AUTHORIZED BY THE ISSUING CREDIT CARD COMPANY, MY POLICY MAY BE TERMINATED FOR NON-COMPLIANCE OF THIS CONDITION OF REINSTATEMENT.

ACCOUNT HOLDER INFORMATION

LAST NAME: _____ FIRST NAME: _____
(AS IT APPEARS ON YOUR ACCOUNT)

MAILING ADDRESS _____
(AS IT APPEARS ON YOUR ACCOUNT)

CITY _____ STATE _____ ZIP CODE _____ -- _____

MUST CHOOSE ONE: ONE TIME ONLY \$ _____

MONTHLY AUTOMATIC (RECURRING) PAYMENT \$ _____

EASY CHOICE HEALTH PLAN OF NEW YORK ACCOUNT # (GROUP ID/MEMBER ID): _____

AUTHORIZED SIGNATURE: _____ DATE: _____

FINANCIAL INSTITUTION INFORMATION

INSTITUTION NAME _____ BRANCH LOCATION _____

ROUTING NUMBER _____ ACCOUNT NUMBER _____

PLEASE MAKE A NOTE ITEMS RETURNED FOR INSUFFICIENT FUNDS WILL BE ASSESSED A \$30 PENALTY FEE. AUTHORIZATION WILL REMAIN IN FULL FORCE AND EFFECT UNTIL EASY CHOICE HEALTH PLAN OF NEW YORK HAS RECEIVED WRITTEN NOTIFICATION FROM THE ACCOUNT HOLDER TO TERMINATE, IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD EASY CHOICE HEALTH PLAN OF NEW YORK A REASONABLE OPPORTUNITY TO ACT ON IT.

YOU CAN FAX YOUR AUTHORIZATION TO 646-929-9222, ATTN: BILLING & ENROLLMENT OR
MAIL TO: EASY CHOICE HEALTH PLAN OF NEW YORK, 45 BROADWAY, SUITE 300, NEW YORK NY 10006

FOR NEW YORK STATE EMPLOYERS

Section 217 of the New York State Labor Law requires that you inform your employees of any plan to terminate their health care coverage. The law requires that a notice from you explaining the reason for the termination be either (1) hand delivered at the place of employment (e.g., by including the notice in the employees' pay envelopes); or (2) mailed to the employees' last known residential address. You must also post a copy of the notice of intent to terminate and the required covering letter in a conspicuous location. These actions must be taken at least nine days prior to the intended termination date.

The law does not apply if, at least 10 days prior to the date of the intended termination, you have (1) taken necessary steps to render an Easy Choice Health Plan of New York notice of termination null and void, such as mailing the required premium; or (2) contracted with another insurer for similar coverage for the same certificate holders, and filed an affidavit with the Commissioner of Labor and Superintendent of Insurance to that effect.

