



CIGNA HealthCare

Easy Pay Authorization

I hereby authorize CIGNA HealthCare* to debit my account at the financial institution identified below on the 5th - 10th day of each month for my monthly CIGNA HealthCare individual plan premium payment. If funds are insufficient, I understand I will be responsible to pay my premium via check or money order received by CIGNA HealthCare before the 30th day of the month in which premium is due.

I understand that this authorization will remain in effect until the earlier of 1) termination of the underlying CIGNA HealthCare individual plan; 2) written notice from CIGNA HealthCare that it will no longer collect premium under this authorization; 3) without written notice, after two attempts to collect my premium results in insufficient funds; 4) the date CIGNA HealthCare is denied access to my account for any reason; or 5) my revocation of this authorization, by submitting written notice two weeks prior to the address listed below. I understand that by revoking this authorization and canceling this service, I am not canceling my health care coverage.

TO START, CHANGE OR STOP EASY PAY:

I wish to: Start Easy Pay _____ Change Easy Pay _____ Stop Easy Pay _____

- Complete all applicable questions and sign form
- Include a voided check. (You will not be set up on Easy Pay unless it is included)

Subscriber Name _____

Subscriber ID _____

Address _____
STREET CITY STATE ZIP

Daytime Telephone _____ Starting Monthly Premium Amount \$ _____

Financial Institution _____ Telephone # _____

Branch Address _____

Account Number _____ Checking _____ Savings _____

Month Requested to begin Easy Pay _____

Account Holder Signature _____ Date _____

IMPORTANT NOTE: Signed authorizations received by CIGNA HealthCare before the 20th day of each month will take effect the following month; those received on or after the 20th day of the month will be effective the following month. (For example, an authorization received on January 27th will take effect in March). Please retain a copy of this authorization for your records and notify us immediately of any changes to the information provided above.

Mail to: CIGNA HealthCare
Attn: Team Facilitators
PO BOX 2010
Concord, NH 03302
Phone: 1.800.753.5190
Fax: 603.268.7578

*Individual HMO plans are offered by CIGNA HealthCare of Arizona, Inc. Individual OAP plans are offered by Connecticut General Life Insurance Company.