## CREDIT CARD/DEBIT CARD PAYMENT AUTHORIZATION

I AUTHORIZE ATLANTIS HEALTH PLAN 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. PLEASE MAKE A NOTE ITEMS RETURNED FOR INSUFFICIENT FUNDS WILL BE ASSESSED A $30 PENALTY FEE.

PRINT NAME AS IT APPEARS ON CREDIT/DEBIT CARD_____

BILLING ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____ PHONE NUMBER_____

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

_____ ___ ___/___ ___ ___ ___
CREDIT/DEBIT CARD NUMBER CARD EXPIRATION DATE

MUST CHOOSE ONE: MONTHLY PREMIUM CHARGE RECURRING ( ) ONE TIME ONLY ( )

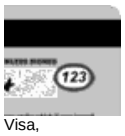
___ ___ ___ ___
Security code

CHARGE TOTAL DUE ( ) CHARGE DIFFERENT AMOUNT: ( ) Specify Amount $_____

ATLANTIS ACCOUNT # (GROUP ID/MEMBER ID) : _____

AUTHORIZED SIGNATURE: _____ DATE: _____

How to Locate Your Security Code



Visa, MasterCard

American Express

## BANK DRAFT (ACH) PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE ATLANTIS HEALTH PLAN 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. PLEASE MAKE A NOTE ITEMS RETURNED FOR INSUFFICIENT FUNDS WILL BE ASSESSED A $30 PENALTY FEE.

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: MONTHLY PREMIUM CHARGE RECURRING ( ) ONE TIME ONLY ( )

CHARGE TOTAL DUE ( ) CHARGE DIFFERENT AMOUNT: ( ) Specify Amount $_____

ATLANTIS ACCOUNT # (GROUP ID/MEMBER ID): _____

AUTHORIZED SIGNATURE: _____ DATE: _____

FINANCIAL INSTITUTION INFORMATION

INSTITUTION NAME_____ BRANCH LOCATION_____

ADDRESS_____

CITY_____STATE_____ZIP CODE_____-_____

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 ATLANTIS HAS RECEIVED WRITTEN NOTIFICATION FROM THE ACCOUNT HOLDER TO TERMINATE, IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD ATLANTIS A REASONABLE OPPORTUNITY TO ACT ON IT.

YOU CAN FAX YOUR AUTHORIZATION TO 212-747-8473, ATTN: BILLING & ENROLLMENT OR
MAIL TO: ATLANTIS HEALTH PLAN 39 BROADWAY SUITE 1240 NEW YORK, NY 10006

ATLANTIS HEALTH PLAN