Print Form

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.

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

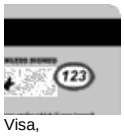
MUST CHOOSE AT LEAST ONE: ONE TIME ONLY $_____

MONTHLY AUTOMATIC (RECURRING) PAYMENT $_____

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

AUTHORIZED SIGNATURE: _____ DATE: _____

How to Locate Your Security Code



Visa, MasterCard

___ ___ ___ ___
Security code

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

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 AT LEAST ONE: ONE TIME ONLY $_____

MONTHLY AUTOMATIC (RECURRING) PAYMENT $_____

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_____

CHECK ONE: SAVINGS ACCOUNT ☐ CHECKING ACCOUNT ☐

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 732-393-7200, ATTN: BILLING & ENROLLMENT OR
MAIL TO: ATLANTIS HEALTH PLAN 90 MATAWAN ROAD, SUITE 204, MATAWAN NJ 07747

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 Atlantis 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.