MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my C.A.R health care dues and/or insurance premiums, adjustments and administration fees due. I agree that your rights in respect to each such debit shall be the same as if it were a check signed by an authorized signer on the bank account. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that RealCare shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month prior to the month of coverage. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the first of the month of coverage. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

C.A.R. Health & Life Insurance Plans Account Information

C.A.R. Member/Employee Name: _____

Phone: _____

Email Address: _____

Banking Information

Name of Bank or Financial Institution: _____

Name on Bank Account: _____

Bank Routing Number: _____ ☐Checking Account

Account Number: _____ ☐Savings Account

Authorized Signature

_____ Date:_____

Signature of Authorized Signer on Above Bank Account

(As it appears in the financial institution's records)

MEMBERS CURRENTLY ENROLLED: Fax or Email this completed authorization and a voided check to: FAX (707) 939-8450 or Email: rc-Enrollment@nfp.com

IF ENROLLING FOR THE FIRST TIME: Please submit a copy of your check with your enrollment application.

Mailing Address: 548 Market St., PMB 91266, San Francisco, CA 94104