Signature Easy Pay

Now you can pay your UnitedHealthcare monthly premiums automatically with Signature Easy Pay. Automatic payment saves you time and gives you peace of mind, since your premium will be paid automatically every month by a withdrawal from your checking account, without you having to mail a check.

How Do Preauthorized Payments Work?

When you complete and submit the authorization form on the reverse side, this allows the payments you have authorized to be withdrawn from your designated checking account. The funds are sent electronically to UnitedHealthcare.

Note: *UnitedHealthcare must receive a 30-day written notification prior to implementing a change or termination of preauthorized payments.*

When Must the Money Be in My Account?

Your bank account must have the full dollar amount due in available funds by the first of the month in order for the current month's preauthorized payment to be made. If your account has insufficient or uncollected funds, your bank will return the preauthorized payment and may charge you just as if you had a check returned for the same reason.

When Will My First Premium Payment Be Deducted?

UnitedHealthcare will notify you of your initial deduction at least 10 days prior to the transaction date. You will need to send in your premium payment until you are notified when your first premium payment will automatically be deducted. All subsequent premium payment deductions will be reflected on the statement from your financial institution.

To sign up for automatic payment of your monthly premium, complete and mail or fax this form along with your voided or clean copy of a check to us as noted below.

Mail:
UnitedHealthcare
Attn: Remittance Easy Pay Setup
PO Box 6044
CA124-0151
Cypress, CA 90630

Fax:
UnitedHealthcare
Attn: Remittance Easy Pay Setup
1-866-392-7071

Call Center:
1-800-591-9911

With the Easy Pay Option, You'll Take Advantage of a Variety of Benefits

- No more checks to write
- Easier reconciliation of your bank account
- Timely payments ensure continuous coverage
- Dollar savings in postage and lower check usage

UnitedHealthcare®

Signature Easy Pay Program Authorization

- Please continue to make your regular payment until notified that you have been set up on the Signature Easy Pay Program.
- Payments will be deducted on the first business day of every month for the month's billed premiums and retro adjustments.
- **Be sure to attach a voided or a clean copy of a check for the checking account you authorize.**
- **Be sure all areas of the form are completed and the authorization is signed by an authorized signer on the account.**
- **Please type or print the information in black or blue ink.**

Check one: ☐ Initial Setup ☐ Change of Account E-mail Address _____

Group Name	Group Number		
Printed Name and Title of Authorized Signer(s) (include Secondary Signer if required)		Phone	
Street Address	City	State	ZIP

Bank Draft Authorization

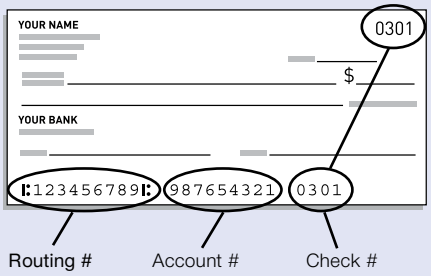
Account Holder	Bank Name	State

Routing/Transit # (9 Digits) (Required)	Account # (Required) (include all zeroes and omit spaces/special characters)	Check # (Required)

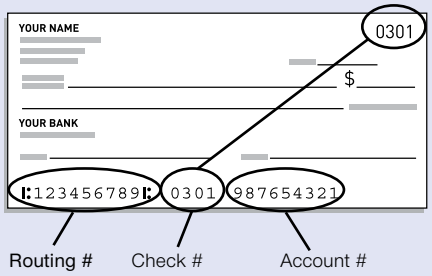
Determining Your Routing Number

To determine your routing number, refer to your personal check. **The routing number is ALWAYS 9 digits long** and it is enclosed by colons. The location of the routing number and account number on your personal check varies depending on your bank; for example:

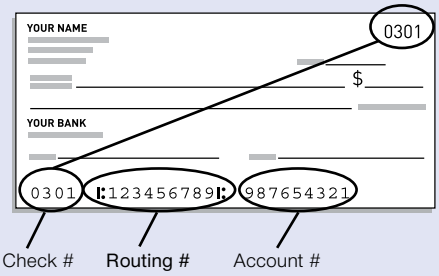
Bank 1



Bank 2



Bank 3



If you are unsure what the routing number/transit number is, your bank can assist you.

Payment Authorization (this section must be completed in full)

I hereby authorize UnitedHealthcare to initiate debit entries to the banking account number listed above. UnitedHealthcare may also initiate, if necessary, any credit entries or adjustments for any debit recorded in error. I will not hold UnitedHealthcare responsible for delay, loss or misapplication of funds due to incorrect or incomplete information supplied by me or my depository, or failure of my depository to correctly debit my account. I understand that an unforeseen delay in processing by an outside entity (financial institution) due to computer downtime, power outages or other unavoidable occurrences might affect the date of charge to funds in my account.

Note: I understand and authorize a $25 service charge may be applied against my account for all denied transactions for any reason. This authorization is to remain in full force and effect until UnitedHealthcare has received written notice of my intention to terminate this agreement.

Signature of Depositor(s) as Shown on Bank Records	Date
Second Signature (if required)	Date

This authorization is to remain in effect until UnitedHealthcare has received written notice of your intention to terminate this agreement. UnitedHealthcare must receive a 30-day written notification prior to implementing a change or termination of preauthorized payments.

For UnitedHealthcare use only: ST_____ RG_____ PR _____ SY _____ CB _____ DT _____

924-CAORWA-041806
PEX241871-001