

Payment Authorization Form

Fill out the following form to allow Oscar to debit the first month's full premium from your bank account or debit card automatically upon approval of your application. You will receive a bill for future monthly payments and are responsible for ensuring Oscar receives future monthly payments after this initial payment.

Billing Information	
Applicant Name (print full name)	
Applicant Date of Birth (dd/mm/yyyy)	
State	

Please choose how you would like to pay your first month's payment. Put a check in the box for either Option 1 or Option 2

Option 1: Debit Card Authorization – Have your first monthly payment automatically deducted from your bank account.

Account Type	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Name	
Account Holder Name	
Routing Number	⑆ 0 7 2 4 0 4 3 3 3 ⑆ 1 2 3 4 5 6 7 8 9 0 Routing number (9 digits) Account number
Account Number	Confirm Account Number

Option 2: Bank Account Authorization – Have your first monthly payment automatically charged to your debit card.

Card Type	<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard
Cardholder Name	
Card Number	
Card Expiration Date (mm/yyyy)	CVV
Billing Address	
Street	
City	State
	Zip

Agreement

I hereby authorize Oscar Insurance Corporation, including its parent, affiliates and subsidiaries (Oscar) to initiate credit/debit entries to the account/card listed above, and, if necessary, initiate adjustments for any transactions credited/debited in error. I understand that payments may take several days to process. This authority will remain in effect until I notify Oscar by calling 1-855-672-2788 to cancel it in such time as to afford Oscar and the financial institution a reasonable opportunity to act on my request.

If payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that debits to the account are electronic transactions and funds may be withdrawn from the account as soon as the date of my authorization. I certify that I am an authorized user of this bank account/debit card and will not dispute these scheduled transactions with my bank or debit card company as long as the transactions correspond to the terms indicated in this authorization form.

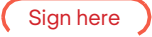
In the case of a transaction being rejected for Non-Sufficient Funds (NSF), I understand that Oscar may attempt to process the charge again within 30 days, and I agree to an additional \$3.00 charge for each

attempt returned NSF and a \$10.00 charge for reversed payments.

I understand that for any items that are disputed there may be a fee assessed in the amount of \$25.00.

I understand that I may request a copy of this signed authorization form.

I understand that this is a one-time payment and that I am responsible for making sure Oscar receives my future monthly payments after this first payment.

Signature of applicant  x.....	Printed name	Date (mm/dd/yyyy)
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Consent to Disclose Form

Fill out the following form to allow your broker or agent to share your personal information with Oscar.

Section A: Applicant Information		
Applicant Name (print full name)		
Applicant Date of Birth (dd/mm/yyyy)		
State		
Section B: Broker or Agent Information		
Broker or Agent Name		
Entity Name (if applicable)		
Phone Number		
Address	Floor or Suite #	
City	State	Zip Code
Section C: Agreement		
<p>I authorize the person or entity listed in Section B to share my nonpublic personal and financial information, including my name and financial account information, with Oscar Insurance Company, including its parent, affiliates and subsidiaries (Oscar). This consent will remain in effect until I revoke or modify my consent by notifying the person or entity listed in Section B or by calling Oscar at 1-855-672-2788. I understand that the person or entity listed in Section B will keep a copy of this document, that I am entitled to a copy of it, and that I may want to make a copy of this document for my records.</p>		
Signature	Printed Name	Date (mm/dd/yyyy)
