UnitedHealthcare®

eBulletin
Important Product Information

UnitedHealthcare New Jersey Individual Marketplace: Tools You Can Use

With open enrollment for 2015 individual coverage well underway, we would like to provide you with some easy reference tools to help you better understand and market UnitedHealthcare individual plans offered to New Jersey residents through the Federally-Facilitated Marketplace (FFM).

New Jersey Individual Exchange Oxford Health Plans, Inc. Compass Plan[1] Overview
We have created an overview flier that you can share with consumers that summarizes our 2015 Individual Exchange portfolio for New Jersey residents.

- Our Individual Compass plans are known for delivering a variety of low cost plan options that provide traditional benefits with the security and guidance of a primary care physician/doctor.
- There are more than 18,000 individual providers in the Compass Network in New Jersey.[2]
- Members can also fill prescriptions at over 60,000 network pharmacies nationwide and have access to a Prescription Drug List (PDL) that is similar to what our non-exchange members have.

New Jersey Individual Exchange Plans At-A-Glance Reference Sheet[3]
For your reference, we have also developed a New Jersey Individual Exchange Plans At-A-Glance comparison grid for agent use. We believe this marketing grid can be a great reference tool for you, however, as this document does not contain complete benefit information, it is not meant for use with consumers.

Not yet appointed with UnitedHealthcare?
Getting appointed is simple. Just follow the steps below:

1. Review the enclosed *New Jersey Prospective Producer Application & Checklist* for the steps you need to take to initiate the appointment process with us.
2. Complete the enclosed *New Jersey Prospective Producer Application*.
3. Submit the *New Jersey Prospective Producer Application* via the email address getappointed@unitedhealthone.com.

More Information
UnitedHealthcare is working to create an integrated shopping and enrollment experience for individuals signing up for plans in the Individual Marketplace. Once you are appointed, we will send you material that may help you with your sales efforts. We look forward to this additional opportunity to work with you.

[1]New Jersey Individual Marketplace products are HMO products that are underwritten by Oxford Health Plans (NJ), Inc.
[2] Physician statistics include MD/DO (excludes hospital-based physicians). Providers are counted one time per county. Individual provider counts are regardless of locations or specialties in the county. A provider may be both a primary care physician and a specialist. Source: Strennus Report (November 18, 2014).
[3] Please note that penalties, up to an including decertification, can result from sharing the UnitedHealthcare New Jersey Individual Exchange Plans At-A-Glance Reference Sheet with the public.

Not For Consumer Use

See if you could save $250 or more per month on health insurance*

UnitedHealthcare has health insurance plans that can deliver the coverage you need at a price that works for you.

New Jersey residents can enroll in one of several Oxford Compass health insurance plans from UnitedHealthcare.

Oxford Compass Plans are known for delivering a variety of low cost plan options that provide traditional benefits with the security and guidance of a primary care physician/doctor; a patient's personal care coordinator. Compass Plans provide well-rounded coverage for many services, with predictable office visit copayments or coinsurance, including:

- preventive care
- primary care physician and specialty office visits
- lab, X-ray and diagnostic services
- urgent care
- emergency services
- inpatient hospital services
- rehabilitation and skilled nursing facility services
- and mental health services

Members can also fill prescriptions at over **60,000 network pharmacies nationwide**.

Learn more – call UnitedHealthcare at 1-844-join-uhc or visit uhc.com/join

With an Oxford Compass Plan, members will have to:

- Choose a network primary care physician (PCP), in the area where the plan subscriber lives. The PCP is the doctor who will help manage and coordinate one's care and must be selected before coverage begins, or one will be assigned.
- Get a PCP's referral to see network specialists. No coverage is provided without a referral – plan members must get care from doctors and facilities within the UnitedHealthcare Compass Network.
- Use UnitedHealthcare Compass Network providers only, except in the case of emergency care.

UnitedHealthcare®

Be confident in choosing a UnitedHealthcare plan.

More than 27 million people across the nation trust us with their health care coverage, and for good reason. We have resources to provide a simpler, more personal health care experience, including:

- A **dedicated member services** team trained to answer members' questions
- Support for people who need help in **other languages**
- **myuhc.com** — a bilingual website available in English and Spanish
- Several **innovative tools and programs**, at no additional cost, to help our members live healthier lives and get the best value from their health benefits

Learn more
Call UnitedHealthcare at 1-844-join-uhc or visit uhc.com/join

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*Projected savings based on qualification for a federal tax credit subject to verification upon filing an individual's federal tax return. In 2014, approximately 87% of individuals in the Federally facilitated Marketplace selected plans with tax credits and these individual have post-tax credit premiums that were 76% (an average of $264) less than full premium, on average. See Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014, June 18, 2014, Department of HHS. Actual savings may vary.

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New Jersey Individual Exchange Plan Options At-A-Glance

Plan type		Copayment Plans				H.S.A. Plans	
Plan Name		**Oxford Silver Compass $2,500**	**Oxford Gold Compass $500**	**Oxford Gold Compass $1,000**	**Oxford Platinum Compass $200**	**Oxford Bronze Compass HSA $2,500**	**Oxford Silver Compass HSA $1,500-2**
Deductible and Coinsurance							
Deductible (Individual)	You pay:	$2,500	$500	$1,000	$200	$2,500	$1,500
Deductible (Family)	You pay:	$5,000	$1,000	$2,000	$400	$5,000	$3,000
Coinsurance	You pay:	50%	20%	10%	10%	50%	20%
Out-of-pocket Maximum (Medical and Pharmacy Combined)							
Individual	You pay:	$6,350	$6,600	$3,000	$2,000	$6,350	$5,500
Family	You pay:	$12,700	$13,200	$6,000	$4,000	$12,700	$11,000
Medical							
Primary Care Physician (PCP)	You pay:	$30	$20	$20	$15	Deductible then 50% coinsurance	Deductible then $25
Preventive Care	You pay:	$0	$0	$0	$0	$0	$0
Specialist	You pay:	$60	$40	$40	$30	Deductible then 50% coinsurance	Deductible then $50
Urgent Care Visit	You pay:	$100	Deductible then 20% coinsurance	$60	$75	Deductible then 50% coinsurance	Deductible then $75
Emergency Room Fees	You pay:	$100 then Deductible then 50% Coinsurance	$100 then Deductible then 20% Coinsurance	$100 then Deductible then 10% Coinsurance	$100	Deductible then 50% coinsurance	Deductible then 20% coinsurance
Outpatient Surgery	You pay:	Deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Deductible then $100
Lab and X-ray	You pay:	$100	Deductible then 20% coinsurance	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Deductible then $100
Hospital Stay	You pay:	Deductible then 50% coinsurance	Deductible then 20% coinsurance	$100 day ($500 max per admit)	Deductible then 10% coinsurance	Deductible then 50% coinsurance	Deductible then 20% coinsurance
Retail Pharmacy (up to a 30-day supply)							
Prescription Deductible	You pay:					Subject to medical deductible	Subject to medical deductible
Tier 1	You pay:	$15	$15	$10	$5	50%	$15 copay after deductible
Tier 2	You pay:	$40	$35	$40	$30	50%	$35 copay after deductible
Tier 3	You pay:	$75	$75	$60	$60	50%	$75 copay after deductible
Pediatric							
Pediatric Vision	You pay:	Deductible then 50%	Deductible then 20%	Deductible then 10%	Deductible then 10%	Deductible then 50%	Deductible then 20%

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New Jersey residents can enroll in one of several Oxford Compass health insurance plans from UnitedHealthcare.

Oxford Compass Plans are known for delivering a variety of low cost plan options that provide traditional benefits with the security and guidance of a primary care physician/doctor; a patient's personal care coordinator. Compass Plans provide well-rounded coverage for many services including: preventive care, primary care physician and specialty office visits; lab, X-ray and diagnostic services; urgent care, emergency services, inpatient hospital services, rehabilitation and skilled nursing facility services; and mental health services – with predictable office visit copayments or coinsurance.

Members will have access to over 18,000 Compass physicians and 65 hospitals[1] in the state of New Jersey.

With an Oxford Compass Plan, members will have to:

- Choose a network primary care physician (PCP) from the registry of New Jersey physicians. The PCP is the doctor who will manage and coordinate one's care and must be selected before coverage begins, or one will be assigned.
- Get a PCP's referral to see network specialists. No coverage is provided without a referral – plan members must get care from doctors and facilities within the UnitedHealthcare network.
- Use Compass network providers only, except in the case of emergency care.

Find the right health care coverage

- Online through healthcare.gov
- Online through uhc.com/join
- By calling UnitedHealthcare at 1-844-joinUHC
- In person, with help from Navigators, insurance brokers or agents

Not For Consumer Use.

[1] Pulse data pull September 1, 2014

Please be advised that this guide is for informational purposes only. We reserve the right to correct any typographical errors.

Our New Jersey Individual Marketplace products are HMO products that are underwritten by Oxford Health Plans (NJ), Inc.

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UnitedHealthOne

Prospective Producer Application Checklist

Oxford New Jersey

1) Complete and return the following:

- ❑ **Prospective Producer Application:**
  - ❑ Prospective Producer Application
  - ❑ Disclosure Authorization

- ❑ **Assignment of Commission Form:**
  This form is required when commissions are being assigned to an assignee.

- ❑ **Independent Producer Contract and Signature Page (IPCSIGPG-1213)**
  - ❑ Review, Sign, Date, and Return the **Signature Page ONLY.**
  - ❑ Retain the entire Independent Producer Contract and a copy of the signature page for your records.

- ❑ **PPA Explanation Page**
  - ❑ This form is required for any of the questions that have a "yes" answer on the Prospective Producer Application.

- ❑ **Direct Deposit Form**
  - ❑ Complete if commissions are assigned directly to you.
  - ❑ Complete if earned commissions are to be paid to you on a weekly cycle. There is a minimum commission draw of $10.00 for a direct deposit payment to occur.
    Note: Unless this form is completed, commissions will be paid to you by method of check on a monthly cycle. There is a minimum commission draw of $500.00 for a check payment to occur.

- ❑ **Agency Affiliation**
  Select the General Agency that you are affiliated with for *Oxford:*
  - ❑ Benefitmall
  - ❑ Slattery GA
  - ❑ Coastal Financial
  - ❑ Emerson Reid
  - ❑ FNA Insurance
  - ❑ Kistler Tiffany Benefits
  - ❑ Martin Financial
  - ❑ PGP Benefits
  - ❑ Savoy Assoicates
  - ❑ Walsh Benefits
  - ❑ None
  - ❑ Other _____

2) Enclose the following:

- ❑ **Copy of your state Health/Life License(s)**
  - ❑ Include non-resident licenses if requesting additional non-resident appointments at this time.

3) Submit forms to:

- ❑ **Email** your completed forms to getappointed@unitedhealthone.com

Or

- ❑ **Fax** your completed forms to 317-297-2077

Note: No business may be solicited until all state licensing and UnitedHealthcare Life appointment and/or contract requirements have been met, and UnitedHealthcare Life has advised you of that in writing.

UnitedHealthOne

PROSPECTIVE PRODUCER APPLICATION

UHCLIC Manager/Representative _____
☐ Independent Producer _____
■ Sub-Producer of Key/FMO Name _____
Key/FMO No. _____

Full Legal Name _____ I prefer to be called: _____
Business Street Address (Required for Supplies) _____

Business Mailing Address _____
City _____ County _____ State _____ ZIP_____
Business Phone (____) _____ Fax (____)_____
E-mail _____
Home Address _____
City _____ County _____ State _____ ZIP _____
Home Phone (____) _____ Birth Date _____ Gender _____
Social Security No. _____ National Producer No. _____
Length of time in present community _____. If less than five years, please provide previous address(es).

Please answer all questions. (If YES, include details of who, what, when, and dollar amounts on an additional form.)

	YES	NO
1. Have you ever had an appointment terminated by any insurance company or financial services institution (for reasons other than production)?	☐	☐
2. Do you owe any debt or balance to any insurance company or financial services institution that has remained overdue for more than sixty (60) days?	☐	☐
3. Has any state or federal agency ever denied, suspended, revoked, or taken any action against any fiduciary license held or applied for by you, or have you ever voluntarily submitted to any sanction or surrendered any fiduciary license under threat of suspension or revocation of that license?	☐	☐
4. Has any state or federal self-regulatory body of any type (such as National Assn. of Securities Dealers) ever taken any disciplinary measures against you?	☐	☐
5. Have you ever had a claim filed against your Errors and Omissions Coverage, or has any bonding company ever denied, paid out on, or revoked a bond for you?	☐	☐
6. Have you ever been the subject of any civil or administrative proceeding, including one initiated by a state department of insurance?	☐	☐
7. Do you have any felony charges pending against you, or have you ever pled guilty or nolo contendere to or been convicted of a felony or a crime involving moral turpitude?	☐	☐
8. Do you have any unsatisfied liens (tax or otherwise) or judgments (civil or otherwise) against you?	☐	☐
9. Have you been the subject of a bankruptcy petition or proceeding in the past seven (7) years?	☐	☐

(1) I hereby represent that the answers and statements ("the information") I am giving UnitedHealthcare Life Insurance Company and its affiliates ("the Company") on this application ("PPA") are correct, complete, and wholly true. **(2)** I understand the Company will rely on the information as one factor in considering this PPA, and may, at its option, terminate or rescind our resulting business relationship if any of the information is not as I have given it. **(3)** I give the Company, its employees, agents, and/or contractors permission to direct advertising or promotional phone calls, faxes, and electronic mail to the numbers and addresses listed above, as well as any others I provide. This permission continues until specifically revoked by me in writing. **(4)** I understand this PPA will not be considered until I sign the FCRA Authorization.

Signature X _____ **Date** _____

NOTE: No business may be solicited until all state licensing and appointment and/or requirements have been met, and you have been advised that fact in writing by the Company.

DISCLOSURE

UNITEDHEALTHCARE LIFE INSURANCE COMPANY AND/OR ANY AFFILIATED COMPANY (COLLECTIVELY, "THE COMPANY") MAY OBTAIN CONSUMER REPORTS AND/OR INVESTIGATIVE CONSUMER REPORTS ABOUT YOU IN CONNECTION WITH YOUR CONTRACT REQUEST, AS WELL AS ANY SUBSEQUENT REQUESTS.

AUTHORIZATION

I authorize The Company to conduct a public records search, and/or to obtain a consumer reports, and/or an investigative consumer reports about me from a consumer reporting agency. These reports may concern my credit history, worthiness, standing, and/or capacity. These reports may also concern my character, general reputation, personal characteristics, criminal, and civil history, and/or mode of living. I understand that The Company will use this information in whole or in part as a factor in considering my initial contract or any subsequent changes in my relationship with The Company.

I understand that if The Company decides not to approve my contract/request and thereby to take adverse action against me because of information contained in any consumer report(s) authorized by my signature on this form, The Company will provide to me:

- A written pre-adverse action disclosure;
- An adverse action notice;
- A copy of any consumer report(s) received and used by The Company;
- A copy of "A Summary of Your Rights Under the Fair Credit Reporting Act"; and
- The name, address and telephone number of any consumer reporting agency that furnished a consumer report about me to them.

I understand that I am entitled to contest the accuracy or completeness of information contained in any consumer report. I understand that I am entitled to receive an additional free copy of any consumer report. I understand that the consumer reporting agency does not itself make any decision regarding my request with The Company, and the agency cannot explain The Company's decision to me.

A photocopy or fax copy of this authorization shall be as effective as the original. This permission continues until specifically revoked in writing by the person who signs below.

Printed Name **Social Security Number**

Signature **Date**

Address

City **State** **ZIP Code**

UnitedHealthOne

PROFILE INFORMATION

1. Over the past 12 months, what percentage of total revenue from your current insurance business does individual health represent? (Check one.)

❑ 0%-10% ❑ 11%-24 ❑ 25%-49% ❑ 50% or more

2. What type of insurance is your <u>primary</u> line of business? (Check one.)

❑ Annuities/LTC
❑ Disability Income Insurance
❑ Financial Services
❑ Group Health
❑ Individual Health
❑ Life
❑ Medicare Business (Part D, Supplement, etc.)
❑ Property/Casualty
❑ Supplemental Policies (Accident, Dental, Vision)
❑ Other

3. How many new individual health applications did you personally write in the past 12 months with all carriers combined—excluding Short Term, Medicare Plans, Employer, and Employer/Group policies? (Check One.)

❑ 0
❑ 1-5
❑ 6-10
❑ 11-2
❑ 21-50
❑ 51-100
❑ 101-200
❑ 201+

4. How many do you plan to write over the next 12 months? (Check one.)

❑ More
❑ Same
❑ Less

5. Which of the following carriers do you consider to be the primary and secondary recipients of your new individual health applications? Please mark your primary carrier with the number 1, and your secondary carrier with the number 2. <u>Please mark 1 and 2 ONLY.</u>

___Aetna
___American Community
___American Medical Security
___Assurant/Fortis/Time
___Blue Cross Blue Shield/ Anthem/Wellpoint
___Celtic
___Cigna
___Coventry/Health America
___Golden Rule/UnitedHealth One/UnitedHealthcare
___Health Net
___Humana One
___Kaiser Permanente
___Mega Life and Health
___Medical Mutual
___PacifiCare
___World Insurance
___Unicare
___None
___Other _____

6. Over the past 12 months, how many of the following products have you personally written?

Short Term Medical Plans
- ❑0
- ❑1-9
- ❑10-24
- ❑25+

Medicare Plans (Supplements, Advantage Plans or Part D)
- ❑ 0
- ❑1-9
- ❑10-24
- ❑ 25+

Health Savings Accounts (HSAs)
- ❑0
- ❑1-9
- ❑10-24
- ❑ 25+

Dental (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Accident (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

Critical Illness (standalone) Insurance Plans
- ❑ 0
- ❑ 1-9
- ❑ 10-24
- ❑ 25+

7. How many states are you licensed in for health insurance?
- ❑ 1
- ❑ 2-4
- ❑ 5-9
- ❑ 10 or more

ASSIGNMENT OF COMMISSIONS AND OTHER MONETARY COMPENSATION

To: UnitedHealthcare Life Insurance Company and/or Golden Rule Insurance Company and/or UnitedHealthcare Insurance Company, and/or All Savers Insurance Company and/or any affiliated company (collectively, "the Company").

If and when the Company owes me compensation because I have sold or secured the sale of insurance products of the Company or for any other reason, I (the undersigned "Assignor") do not wish to receive that compensation, but instead assign it to, and direct the Company to pay it to, the person or entity I have written below as Assignee per my applicability instructions below:

PLEASE PRINT _____ _____

Assignee Name (person/entity to be paid) Social Security/tax ID Number

PLEASE PRINT _____

Street City State ZIP Phone

This Assignment applies to (select and complete **option 1 OR 2** below):

1. ■ **All monetary compensation including commissions, monetary bonuses, monetary incentives/prizes.**
   (in addition, check one box below)
   ■ all monetary compensation attributable to my business written ***after*** the date this form is processed by the Company
   OR
   □ all monetary compensation for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to the Company)

.

2. □ **Commissions only (monetary bonuses and monetary incentives/prizes will be paid directly to you)**
   (in addition, check one box below)
   □ all commissions attributable to my business written ***after*** the date this form is processed by the Company
   OR
   □ all first year and renewal commissions for all business issued, including any business issued prior to this date (only allowed if no prior Assignment has been submitted by the Assignor to the Company)

I understand and agree that:

1. Payments made by the Company pursuant to this Assignment fully discharge all of the Company's financial obligations to me under any compensation arrangement between us.

2. This Assignment is subject to, and does not affect, any terms or conditions of any such compensation arrangements except as specifically provided herein.

3. This Assignment is subject to applicable state and federal laws regarding assignment of commissions by insurance producers (by whatever name called). The Company will not be bound by this Assignment in any instance in which it believes applicable law prevents it from paying the Assignee, and it then may pay the person or entity that it, in its sole discretion, determines to be appropriate under the circumstances.

4. This Assignment shall remain in effect, and is binding on both myself and the Company, until revoked. I may revoke this Assignment by sending written notice to the Company. Such revocation will only apply to business written after the effective date of the revocation, and this Assignment will remain in effect for business written for the Company prior to that date. Revocation will be effective on the later of the date I request, or not later than thirty (30) days after the Company's receipt of the notice.

5. This Assignment does not apply to non-monetary incentives/prizes (e.g., merchandise, trips, non-cash incentives, awards, contest results, or any other non-cash remuneration).

6. Assignor understands the Assignee may enter into a Commission Advance Agreement ("Advance Agreement") with the Company. The Advance Agreement entitles the Assignee to receive an advance on the payment of compensation for business issued by the Company after the effective date of the Advance Agreement. Assignor understands and acknowledges that the Company, as a condition to agreeing to the Advance Agreement, requires the Assignee to obtain Assignments from all sub-brokers, including the Assignor. Assignor further agrees that commissions attributable to any business written by the Assignor that are advanced to the Assignee under their Advance Agreement are hereby assigned to the Assignor, even if the business was written prior to the date of this Assignment.

_____ _____

Assignor Signature Date Signed

_____ _____

Assignor Printed Name Social Security/Tax ID Number

PPA Explanation Page

This page is required for any of the questions that have a "yes" answer on the Prospective Producer Application. A detailed explanation is needed and should include who was involved, when it occurred, dollar amounts, detailed information as why it occurred and steps taken to resolve issue.

Producer Name: _____

Producer number: _____

Question # _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Producer Signature Date

-SIGN AND RETURN THIS SIGNATURE PAGE-

INDEPENDENT PRODUCER'S CONTRACT
SIGNATURE PAGE

I acknowledge and agree that:

(a) I have received a copy of the Independent Producer Contract (IPC-1213),

(b) I have read, understood, and agreed to each and every term of the Contract, any and all provisions of which provisions of which cannot be altered without the express written consent of UnitedHealthcare Life; and

(c) This Contract will not be in effect until such time as UnitedHealthcare Life has countersigned this Signature Page.

(d) The Contract may be executed in two or more counterparts, any of which need not contain the signature of more than one party, but all such counterparts when taken together will constitute one and the same agreement.

YOU: _____
Print or type your name

X _____
Your signature Date:

AUTHORIZATION AND AGREEMENT FOR ELECTRONIC DIRECT DEPOSIT

By completing and signing this form, I hereby authorize UnitedHealthcare Insurance Company and/or any affiliate company (collectively, "the Company") to electronically deposit (and the Financial Institution to accept) my future commissions, and other compensation payable in cash (collectively "Commissions"), into the account listed below.

I understand the deposits will be based upon, and are subject to, the terms and conditions of my compensation agreement(s) with the Company, and that the amounts of the deposits will fluctuate. I also authorize adjustment of any deposit made in error. I agree to hold the company harmless for any charges or damages, direct or indirect, related to the amount of, or the timing of, the deposits or adjustments.

I understand that the Company will make every effort to deposit Commissions on the same working day(s) following each commission cycle, but that the Company cannot and does not guarantee that will occur. I understand that other compensation, depending upon its nature, may not be payable or paid according to any schedule. I agree to hold the Company harmless for any charges or damages, direct or indirect, related to the amount of, or the timing of, the deposits or adjustments.

I agree to receive my commissions deposit as indicated below and view my commission statements via the Internet-based system(s) provided by the Company, and that making them available in this manner satisfies the Company's periodic statement and/or accounting obligations.

I understand that the Company will make reasonable efforts to timely process this authorization, or any changes to it, including revocation. However, I understand that such processing may not occur prior to the next deposit. I therefore agree that the prior compensation arrangements between us will continue until this authorization is processed. I agree to provide the Company and the Financial Institution advance written notice of revocation of this authorization. This form is not, nor does it act as, an assignment of commission.

Complete this section if you are a PRODUCER directly receiving compensation (commission and/or bonuses).

Printed Producer Name _____ Producer ID/NPN _____

Producer Signature _____ Date _____

Complete this section if you are an AGENCY receiving compensation.

Printed Agency Name _____ Agency ID/NPN _____

Printed Name of Principal/Officer/Authorized Agency Representative of Agency _____ Title _____

Signature of Officer or Authorized Agency Representative _____ Date _____

Account Holder Name *(as it appears on the account)* _____

Financial Institution _____

Address _____

City _____ State _____ ZIP Code _____

Phone *(including area code)* _____

Type of Account: ❑ Checking ❑ Savings

Deposit Frequency: ❑ Monthly ❑ Weekly

1. Write your *nine*-digit **routing** number for your financial institution here:

❑❑❑ ❑❑❑❑❑❑

2. Write your **account** number here:

❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑

(You can also find your account number by looking on your most recent financial institution statement.)

Attach Voided Check Here
-OR-