OXFORD HEALTH PLANS®

A UnitedHealthcare Company

SCHEDULED DIRECT DEBIT AUTHORIZATION FORM

Oxford Health Insurance, Inc. ("Oxford Health Plans"), Oxford Health Plans (NY), Inc. ("Oxford Health Plans"), Oxford Health Plans (NJ), Inc. ("Oxford Health Plans"), Oxford Health Plans (CT), Inc. ("Oxford Health Plans"), Oxford Health Plans LLC ("Oxford Health Plans")

Enrollment Instructions

1. Complete and sign the authorization section below.
2. List all customer numbers that you wish to have paid by automatic withdrawal.
3. Provide a voided check from the account in which the funds will be drawn upon.
4. Fax this information to the fax number on the bottom of the form.

STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Debit, I agree to and understand all of the following on behalf of my group:

I understand it may take up to one month to establish a Direct Debit from the indicated account for premium payment. I understand that if premium payment is overdue at the time of establishing Direct Debit, a delinquency letter will be sent. I understand that failure to pay premiums due while Direct Debit is being requested may result in cancellation of coverage. I authorize Oxford Health Plans to debit my group's checking or savings account for all monthly premium charges for coverage. I understand it is my responsibility to ensure that sufficient funds to cover premium due are in the checking or savings account registered for Direct Debit. I understand it is my responsibility to provide Oxford Health Plans with a voided check from the account from which the funds will be withdrawn. If the necessary funds are not on deposit in the account at the beginning of the month, the group's coverage may be subject to termination under the terms stated in the contract with Oxford Health Plans. Oxford Health Plans reserves the right to collect any additional fees incurred resulting from insufficient funds. I understand that collection of such fees might occur after termination. I understand it is my responsibility to promptly notify Oxford Health Plans of any change to the group's checking or savings account. If such a change occurs, I understand it is my responsibility to provide Oxford Health Plans with the new information, with reasonable advance notice of any such change.

AUTHORIZATION

As an authorized representative of the group listed below, I hereby authorize Oxford Health Plans to initiate electronic transactions debiting my account (payments) from the financial institution indicated below for the purpose of paying the group's monthly bill. If ever a debited amount needs to be adjusted, Oxford Health Plans is authorized to make such adjustment. The financial institution indicated below is authorized to debit or adjust the account listed below, accordingly. This authority is to remain in full force and effect until it is cancelled by Oxford Health Plans under the conditions stated above, or upon termination of my group's coverage with Oxford Health Plans. I have also read and, on behalf of the group, agree to the terms and conditions outlined above.

Authorized Signature _____ Title _____ Date _____

Employer Name/Customer Name/Policy Name _____

Group/Customer Number _____

Name of Your Group's Financial Institution and City, State _____

Phone Number of Financial Institution _____

Transit / ABA # _____ Account Number to Debit _____

Type of Account (Checking or Savings) _____

OXFORD HEALTH PLANS
ATTN: COLLECTIONS DEPARTMENT
48 MONROE TURNPIKE
TRUMBULL, CT 06611

PHONE # 1-800-366-4148
FAX # 203-459-7372

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