



**MONTHLY CHECKING/SAVINGS ACCOUNT  
AUTOMATIC PREMIUM PAYMENT AUTHORIZATION**

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I 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 health care dues and/or insurance premiums, adjustments and administration fees due. 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 you 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 following the due date. 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 fifth of the month following the due date. 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.

***Policyholder Information***

Policyholder name: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

***Banking Information***

Name of bank or financial institution: \_\_\_\_\_

Bank Account Name: \_\_\_\_\_

Checking Account     Savings Account    Account Number: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

***Authorized Signature***

\_\_\_\_\_ Date: \_\_\_\_\_

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

**MEMBERS CURRENTLY ENROLLED: Fax this completed authorization  
and a voided check to: (707) 939-8450**  
**IF ENROLLING FOR THE FIRST TIME: Please attach a copy of your check and  
submit with your enrollment application.**