HIP Sole Proprietor Plan Application Process

The following application may be completed on your own, or you may call our office to complete over the phone. The deadline for applications is two weeks prior to the intended start date (e.g. 15th of month for a 1st of next month start date)

Mail signed application along with first month premium made out to: United Association of Entrepreneurs or UAE

One check may be submitted covering the first month premium plus the $35 UAE association membership fee.

Submit application, premium and tax documents to:

Life and Health Quote Corp.

560 Broad Hollow Rd. Ste. 313

Melville, N.Y. 11747

Phone: 631-393-2700

UAE Enrollment Instructions for HIP

Benefits are available to individual self employed & businesses of 2-50 employee's.

- The **deadline** for submitting new HIP applications to a new or existing group is the **15th day of the month prior to the effective date** *(**NO EXCEPTIONS**)*.
- Benefit coverage is **effective** the first of the month and **terminated** the last day of the month.
- All premium checks must be made payable to **UAE** or to the **United Association of Entrepreneurs**.

REMEMBER: ALL FUTURE PREMIUMS ARE DUE BY THE 15TH OF THE MONTH PRIOR TO EACH MONTH OF BENEFIT COVERAGE.

Please submit the following with each enrollment:

UAE Membership Application:

1. Your UAE membership application **MUST** be completed and signed for either Gold or Affiliate membership. Annual membership dues are $199 for Gold / $35 for Affiliate.
2. Please include a separate check with your premium, also payable to **UAE**.

Payment Methods:

Please select either direct billing or electronic billing (ACH) on a monthly or quarterly calendar-year basis.

Proof of Prior Coverage:

Please be sure to submit proof of prior coverage in order to waive any pre-existing conditions and waiting periods. Your previous carrier **MUST** supply you with a certificate when notified of termination of policy.

Proof of Business: (All documents* MUST *be submitted and signed)

Please see <u>Documentation Requirements</u> for proof of business status filings.

Change of Status:

1. You **MUST** notify the UAE office of any change in status within 30 days of the event. *(Marital or childbirth)*
2. Terminations by request **MUST** be in the UAE office 30 days prior.

Student Status:

You must submit proof of Student dependent status with all applications (see Student Recertification form)

Nonpayment:

Nonpayment of premiums will result in termination of coverage. Any reinstatements must conform to current UAE/HIP and procedures in effect at that time.

Enrollment Checklist: The following MUST be submitted with all applications:

- ☐ HIP Group Application
- ☐ Plan Selection
- ☐ HIP Employee Enrollment Application
- ☐ HIP Participation Agreement
- ☐ UAE Membership Application
- ☐ UAE Submission Form
- ☐ Proof of Student Status **(see *Student Recertification form*)**
- ☐ Check-O-Matic Request Form: If submitting **Check-o-matic**, please attach a voided business check.
- ☐ One Check payable to **UAE** for insurance premium and membership
- ☐ Proof of Business: **(see attachment for acceptable documentation)**
- ☐ Proof of Prior Coverage: In order to waive pre-existing conditions

If you have any questions, please contact UAE's Enrollment Department at:
(516) 938-9100 or (800) UAE-3393

United Association of Entrepreneurs

Enrollment & Renewal Documentation Requirements

In order to Enroll or Renew your policy in compliance with applicable laws and regulations, UAE and all health care providers, require that you provide the most **recent** proof of business filing status. All Eligible businesses must be **actively** in business.

* **Note**: Applications submitted *without* **recent** proof of business will **NOT** be processed and *only fully executed* documentation with **signatures** will be accepted.

The following documentation will be required depending on status:

If Company is Filed as a:	Required Documentation Needed:
Corporation	Form 1120 or 1120S with supporting Payroll Documentation NYS-45, or K-1 accompanied by 1st 2 pages of 1040, & Schedule SE
Partnership	Form 1065, with supporting Payroll Documentation NYS-45, or K-1 accompanied by 1st 2 pages of 1040, & Schedule SE
Limited Liability Corporation	LLC agreement and depending on state law, they may file as a Corporation or Partnership. *See above guidelines.*
Proprietorships	NYS-45 (indicating all eligible employees), or Schedule C, & Schedule SE accompanied by 1st 2 Pages of 1040. Only owners of a SP can take a draw from the company and still be considered an eligible employee.
Sole Proprietors (1099's)	Schedule C , Schedule SE: Self Employment Tax; accompanied by 1st 2 pages of 1040 Profit or Lost from Business.
Church	Form 941 with supporting NYS-45
Husband & Wife Groups	Same requirements as any Two (2) Life Group. NYS-45 must list both as employees.
Add-on Employee	Must be on NYS-45; **If new employee**: A copy of W-4 with current paycheck that shows the front and back.

Please submit all documentation to:

UAE
397 Central Avenue
Bethpage, NY 11714
or…
Fax to: (516) 942-8626 or (516)942-8623

If you have any questions, please do not hesitate to call us at 1-800-823-3393.

United Association of Entrepreneurs

GROUP APPLICATION for HIP

BE SURE TO MAINTAIN CURRENT COVERAGE UNTIL YOU RECEIVE APPROVAL FROM HIP

Company Name: ____

Address: ______________________ City/State: ______________ Zip: __________

Company Phone #: ________________ Type of Business: ______________________

Contact: ________________________ Title: ______________

Total Number of Employees: ________________

Total Number of EE's working 20 hours or more a week: ________________

Total Number of eligible employees: ________________

Total Number of subscribers enrolling: ________________

Single: _______ Employee/Spouse: _______ Employee/Child: _______ Family: _______

Present Insurance Carrier: ______________________________

Dates of Coverage: From ____/____/______ To: ____/____/______

Waiting Period for new employee's ___30 ___60 ___90 ___120 ______Other

Requested Effective Date: ____/____/______

GUIDELINES FOR ALL PLANS

1. The employer must be a member in good standing of United Association of Entrepreneurs.
2. All payments must be made to United Association of Entrepreneurs or UAE.
3. All applications must be accompanied by a business check and proof of business status, see documentation requirements.
4. All members must be self employed or have employer/employee relationships.
5. We can not accept enrollments if they are not properly completed, and accompanied by premium payment.
6. Enrollment, changes and cancellations must be in the administrative office at least 15 days prior to effective date.
7. Your premium must be received before the 1st of the month of coverage to avoid termination of coverage.
8. Student dependents must submit proof of student status, see Student Recertification Form

Plan Applied for (Check One Plan) Sole Proprietors & Groups 2-50 Employee's

- ☐ **1B - Prime HMO (30/50/1,000/150) with Generic RX only**
- ☐ **2B - Prime HMO 30/50/1,000/150) with RX $20/30/50 $300 Deductible**
- ☐ **3B - Select PPO (30/50/Ded & Coins /150) with Generic RX only**
- ☐ **4B - Select PPO ((30/50/Ded & Coins /150) with RX $20/30/50 $300 Deductible**

All premiums must be made payable to UAE or United Association of Entrepreneurs

The information provided above is true and correct to the best of my knowledge. I understand that coverage and benefits may be affected by failure to provide complete and accurate information. I understand all current employees have the option of joining HIP now, or on my group's annual anniversary date.

______________________ ______________________

Signature of Owner Representative

______________________ ______________________

Date Representative's Phone Number

United Association of Entrepreneurs
397 Central Avenue, Bethpage, New York 11714
1 (800) UAE - 3393 or (516) 938-9100 Fax (516) 942-8626
www.uaebenefits.com

Company Name): ____
(as it appears on Taxes)

Requested Effective Date: ________________

HIP Sole Proprietor Plan Selection (Check One Plan)

Two Tier Plans

_____**#1B Prime HMO (30/50/1000/150) with Generic RX**

_____**#2B Prime HMO (30/50/1000/150) with RX: $20/30/50**

_____**#3B Select PPO (30/50/Ded & Coins/150) with Generic RX**

_____**#4B Select PPO (30/50/1000/150) with RX: $20/30/50**

	STATUS	Plan #		AMOUNT
_______	Single	________________	=	$ ______________
_______	Family	________________	=	$ ______________

TOTAL DUE: $ _________________________

Please make premium check payable to:
UAE or United Association of Entrepreneurs

Signature: ____

Title: _________________ Date: _______________

Broker's ____________________________________Date:_____________

Name (only if applicable)

UAE Membership Application

United Association of Entrepreneurs • 397 Central Avenue • Bethpage, NY 11714 • Fax (516) 942-8626

Please Print Clearly

Company Name:	*Employer ID #:*
Owner/Officer:	*SSN:*
Street Address:	*Phone:*
City, State, Zip:	*Fax:*
Website:	*Email:*
Organizational Structure:	☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Independent Contractor
Business Classic:	☐ Retail ☐ Wholesale ☐ Manufacturing ☐ Services ☐ Professional
Nature of Business:	*# of Employees :*

I hereby certify that I am an entrepreneur, and I would like to become a member of the United Association of Entrepreneurs so that I may take advantage of the many time & money saving benefits available through UAE membership. I am enclosing payment for annual membership dues, as indicated below. I hereby acknowledge and agree that membership dues are on an annual basis and that I will be billed for renewal on my enrollment anniversary. I also acknowledge that, as a member in good standing, UAE will continue to negotiate additional benefits on my behalf and will advise me, as they become available.

Business Owner's Signature : Date:

Please Check only one type of membership

☐ Annual Gold Membership $ 199 Per Year

Gold Members Receive the following :

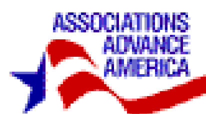
Affordable Group Health Plans to choose from
Basic listing in our Web Bases Business to Business Website
Personalized Certificate of membership
Free Business and Personal Checking
Full Access to UAE Member's Website
Subscription to monthly member to member newsletter & special 10% discount on advertising in member to member newsletter.
Access to 120 Benefits and services providing substantial savings in these categories:

Banking & Financial Services
Business Products & Services
Car Rentals
Dental Plans
Discount Health
Emergency Assistance
Employee Assistance & Counseling
Employer Resources
Website Development
UAE Group Health Plans
Optional Group Health Plans
Insurance Services
Miscellaneous Benefits
Payroll Administration Services
Professional Services
Shipping
Training

☐ Annual Affiliate Membership $ 37 per year

Affiliate Members Receive the following :

Access to selected business benefits, ranging from Credit Union membership to prepaid shipping benefits.
Selected Group Health plans to choose from (Atlantis, GHI, MDNY & HIP / Vytra Plans)
Free Business and Personal Checking
Personalized Certificate of membership
Access to UAE's Member Website (Limited time only)
Website Development
Subscription to monthly member to member newsletter



Mail or Fax this application back to :
United Association of Entrepreneurs
397 Central Avenue
Bethpage, New York 11714
Fax (516) 942-8626

Payment Options: ☐ I have enclosed a business check made payable to **UAE**

☐ Please Charge my: ☐ Visa ☐ MasterCard ☐ American Express

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration Date __ __ / __ __

Authorized Signature :

Name as it appears on credit card (please print) :

Below this line is for UAE member Service

Date Received :	Processor :
Status/Action :	

HIP Subscriber/Member Enrollment Form

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	Zip Code

Were you ever a member of HIP? ☐ NO ☐ YES
If yes, indicate policy number(s): ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced

Birth Date: Mo. Day Yr.

Telephone #: Home: (____) ____________ Work: (____) ____________
E-Mail Address: ____________________

Primary Care Physician: (*not required for EPO/PPO members*)
Physician Name ____________
Physician ID Number ____________

OB/GYN Selection: (*Optional*)
Physician Name ____________
Physician ID Number ____________

Prior Health Insurance Information
Carrier Name ____________________
Coverage Begin Date __/__/__ Coverage End Date __/__/__

Qualifying Event: ☐ Birth/Adoption ☐ Marriage ☐ Loss of Coverage ☐ New Hire ☐ ____________ **Qualifying Event Date:** Mo.____ Day____ Yr.

Are you covered by any other Health Insurance or Medicare?
☐ NO ☐ YES If yes, indicate:
Insurance Co. Name: ____________
Insurance Co. Telephone #: ____________
Type of Coverage: ____________
Policy #: ____________ Effective Date: ___ / ___ / ___

Is your spouse covered by any other Health Insurance or Medicare?
☐ NO ☐ YES If yes, indicate:
Insurance Co. Name: ____________
Insurance Co. Telephone #: ____________
Type of Coverage: ____________
Policy #: ____________ Effective Date: ___ / ___ / ___

**** If you are enrolling for your spouse and/or children, please list each one below – see Election of Coverage for eligibility***

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date Mo.	Day	Yr.	Check if disabled	Primary Care Physician Name/Number (not required for EPO/PPO members)	OB/GYN Selection Name/Number (Optional)
SPOUSE		___-__-____		☐ Wife ☐ Husband ☐ Other						
Prior Health Insurance Information		Carrier Name ____________		Coverage Begin Date__/__/__				Coverage End Date __/__/__		
ADDITIONAL DEPENDENTS (List oldest first)		___-__-____		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ____________		Coverage Begin Date__/__/__				Coverage End Date __/__/__		
		___-__-____		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ____________		Coverage Begin Date__/__/__				Coverage End Date __/__/__		
		___-__-____		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ____________		Coverage Begin Date__/__/__				Coverage End Date __/__/__		
		___-__-____		☐ Son ☐ Daughter						
Prior Health Insurance Information		Carrier Name ____________		Coverage Begin Date__/__/__				Coverage End Date __/__/__		

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form

Applicant must sign here: ____________________ **Date**____________

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group	Group Number

Select One: ☐ HIP PRIME HMO ☐ HIP PRIME POS ☐ HIP SELECT EPO ☐ HIP*access* I ☐ HIP*access* II ☐ HIP SELECT PPO ☐ HIP PRIME EPO ☐ HIP PRIME PPO ☐ HIP CLASSIC HMO

Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by (*Representative of Benefits Administrator*)

Type of Coverage: ☐ Individual ☐ Employee & Spouse ☐ Family ☐ Employee & Child

Instructions to Benefit Administrators or Group Representatives: For Groups with 50 employees or less, you **MUST** complete Section A on the reverse side of this form. Required documentation MUST be attached to this Enrollment Form to be processed.

FOR HIP USE ONLY

PROCESSED BY	RECEIVED DATE	PROCESSED DATE

FORM 16-1613 10/02

HIP HEALTH PLAN OF NEW YORK, P.O. Box 2806, New York, NY 10116-2806

9798/m

ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

HIP PRIME POS and HIP*access* II applicants please note that your benefits are provided under two separate contracts: a HIP, HMO contract issued by the Health Insurance Plan of Greater New York and HIP PRIME POS and HIP*access* II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP*access* II coverage ends.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A

DOCUMENTATION BASED ON GROUP SIZE

(To be completed by Benefits Administrator)

Group Type (Check One) →

ACTION **Check (✔) One**	**Qualifying Event**	**Documentation Required**	☐ **Sole Proprietorship or One Subscriber Group**	☐ **Association of Two or More Employees**	☐ **Small Group - Less Than 50 Employees**
☐ Add Subscriber	New Hire **or** Change in Plan	For eligible employees who work more than 20 hours weekly provide a recent Copy of NYS45 showing this subscriber as an employee **or** copy of Payroll documentation reflecting the date, employee's name and Social Security # **and** the employee's current year W4 form.	Not Eligible		
☐ Add Spouse	Marriage	Marriage Certificate			
☐ Add Dependent	Birth	☐ Birth Certificate or			
	Adoption	☐ Formal Adoption Papers or			
		☐ Court Approved Guardianship Papers			
☐ Add Spouse ☐ Add Dependent	Loss of Coverage				
		Certificate of Creditable Coverage			

Note: *No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.*

CERTIFICATION OF SOLE PROPRIETOR STATUS FOR COVERAGE WITH HIP HEALTH PLAN OF NEW YORK

I, ____, hereby affirm that I am self-employed, on a full-time basis, working 20 or more hours a week. As proof of my employment status, I have enclosed a copy of my most recent federal tax return (which includes a completed schedule C). I agree to notify HIP Health Plan of New York (herein after, "HIP") immediately if my circumstances change and I am no longer self employed.

I acknowledge and agree that it is fraudulent act subject to criminal and civil penalties to knowingly and with intent to defraud file an application for insurance (including any supporting certifications) containing any materially false information, or which conceals for the purpose of misleading, information concerning any fact material hereto. I further acknowledge and agree that filing a false or misleading insurance application with HIP or failing to notify HIP if I am no longer self employed shall render any health insurance contract entered into with HIP null and void.

I certify that this certification and my enclosed federal tax return are true, correct and complete.

Signature____

Date____

HIP

United Association of Entrepreneurs

PARTICIPATION AGREEMENT

COMPANY NAME: ____

I confirm that the above named company is complying with United Association of Entrepreneurs participation requirements. The following employees are regularly employed on a full-time basis working at least 20 hours per week:

Employee Name	Employment Date	Present Coverage	New Coverage

I hereby represent and agree that all answers and statements in this statement are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements from the basis upon which insurance will be effective. I understand that omission, misrepresentations and misstatements about employee history could result in denial of an otherwise valid claim and voiding of insurance.

______________________________________ ______________________________________
Signature of Owner Print Name

______________________________________ ______________________________________
Title Date

______________________________________ ______________________________________
Witness Print Name

UNITED ASSOCIATION OF ENTREPRENEURS
397 Central Avenue Bethpage, NY 11714
1(800) UAE-3393• (516) 938-9100 • (516) 942-8626 fax
www.uaebenefits.com

Submission Form

NEW MEMBER INFORMATION

Company Name: ______________________

Owner/Officer: ______________________

Billing Address: ______________________

City, State, Zip: ______________________

Business Phone# : (   )   Fax#: (   )

EID# or Employer SSN: ______________________

HEALTH PLAN INFORMATION

Plan Type/Option: ❑ HMO____ ❑ POS_____ ❑ PPO_____ ❑ DENTAL

Action: ❑ NEW ACCOUNT ❑ ADD-ON ❑ TRANSFER

Specify Healthcare ______________________

Effective Date (mm/dd/yy): / /

TIER LEVELS:	# Participants:		Premium		Months Paid	TOTALS
Employee-Only Plans:	_________	x	$_________	x	_________	$______________
Two-Party Plans:	_________	x	$_________	x	_________	$______________
Full-Family Plans:	_________	x	$_________	x	_________	$______________
Dental Plans:	_________	x	$_________	x	_________	$______________

Annual Membership fees: ❑ UAE GOLD: $199 ❑ UAE Affiliate: $37 Selected Plans $______________

BILLING MODE: ❑ MONTHLY ❑ MONTHLY Check-O-Matic ❑ QUARTERLY

TOTAL AMOUNT COLLECTED: [ ]

AGENCY INFORMATION

Agency Name: UAE

Agency Phone #: (   )   Agency Fax#: (   )

Agent's Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Agent's Phone# : (   )   Agent's Fax#: (   ))

Agent/Producer Signature: ______________________ Date:

HEALTH PLAN OF NEW YORK

STUDENT RECERTIFICATION

Subscriber Name: ______________________________

Address: ______________________________

____

Dependent Name: ______________________________

HIP ID #: ______________________

The dependent whose name appears above will no longer be entitled to dependent coverage under your HIP policy. You may, however, continue to keep the dependent on your policy if she/he is unmarried and either:

1. A full-time student at an accredited institution of learning; or
2. Unable to work or support himself/herself because of mental illness, developmental disability, mental retardation or physical handicap. You must submit proof of the disability and/or condition within 31 days.

If one of the above applies, complete BOTH requirements of this letter (Subscriber Attestation and Proof of Status) and mail, along with the appropriate documentation, to:

HIP Health Plan of New York
Attn: Enrollment, Fourth floor
P.O. Box 2794
New York, NY 10117

or **fax** all documents together, to the attention of: Student Recertification **1-646-447-3089.**

To ensure proper recording of this information, indicate the dependent's HIP ID # on all documents faxed.

Failure to return the documentation or completely respond to this letter will result in termination of coverage for the above-named dependent.

If you have any questions, contact our Customer Service department at **1-800-HIP-TALK (1-800-447-8255)** Monday through Friday 8 am to 6 pm.

SUBSCRIBER ATTESTATION

- Full-time student? ☐ Yes ☐ No
- Is this dependent handicapped? ☐ Yes ☐ No

I certify that this dependent is an unmarried child currently attending an accredited educational institution.

____

Subscriber's signature Date

THIS SECTION TO BE COMPLETED BY THE EDUCATIONAL INSTITUTION ONLY
(or attach certificate from Registrar's Office regarding full-time student status)

PROOF OF STATUS

Name of Institution: ______________________________

Address: ______________________________

Telephone: (______) ______ - ________

This is to confirm that ______________________ is registered as a full-time student.

____

Registrar's signature Date

© Astoria Graphics, Inc.

Check-O-Matic Pre-Authorized Bank Check Plan

The modern way to make monthly payments!

Payments will always be on time, will always be for the correct amount.. with no unintentional lapse of healthcare protection.

- **Never a check to write**
- **No postage stamps to bother with**
- **No notices to remit**

Request for check-o-matic plan

I/we hereby request the privilege of paying premium contributions to the United Association of Entrepreneurs, under the Company's Check-o-Matic Plan and hereby request the company to initiate debit entries, electronically, by paper means or by any other method. Check the payment option/draft date:

- ☐ **Monthly :** On or about the 20th of each month,prior to coverage effectiveness
- ☐ **Quarterly :** On or about the 20th of each calendar year quarter, prior to coverage effectiveness

The privilege of paying premium contributions under this plan may be revoked by the company if any ckeck or debit entry is not paid upon presentation.The payment to premium contribution under this plan may also be discontinued by the Company or the undersigned upon thirty (30) days written notice. This plan shall not modify any prevision of the policy and I agree that presentation of a check or debit entry to the bank will constitue notice and when paid will constitue a receipt. I understand that if more then one policy is drafted at the same time, only one policy may be shown on my statement.

Name As Shown On Checking Account: ______________________________

Note: This should agree with bank signature - include name of firm if check are to be drawn from business account

Please Attach Voided Check

AUTHORIZATION TO DEBIT ENTRIES DRAWN BY THE UNITED ASSOCIATION OF ENTREPRENEURS

Bethpage, New York

1 (800) UAE-3393

______________ Date

______________ Check Account #

______________ Bank Signature of Premium Payor

______________ Bank Name

______________ Street or P.O. Box

______________ City State Zip

As a convenience to me,I hereby request and authorize you to pay and charge to my account debit entries initiated by and payable to the United Association of Entrepreneurs, Bethpage, New York provided that there are sufficient funds in said account to pay the same upon presenta- n. Debit entries may be in form or check drawn the account or otherwise. I agree that your rights in respect to each such debit shall be the same as it was a check drawn and signed personally by in writing and until you actually recieve such notice.I agree that you shall be fully protected in honoring such charges. I futher agree that if any such debit entry be dishonored, whether intenionally or inadvertently, you shall have no liability whatsoever.