

Individual Health Plan List Bill Election Form

- I hereby elect the List Bill Premium Payment Option for my health plan. I understand and agree that:
- I am authorizing the Third Party to submit premium payments including any fees for myself and any dependents (if applicable) for coverage.
 - The monthly List Billing statement will be sent directly to the Third Party.
 - The Insurance Company has no obligation to guarantee coverage or any other liability in the event that coverage lapses due to the Third Party's failure to submit premium payment by the due date.
 - I may cease to participate in the List Billing Agreement upon giving 30-day prior written notice and may send future payments directly to the Insurance Company's administrator, Insurers Administrative Corporation (IAC).*
 - Should the List Billing Agreement terminate, IAC will send future bills (on a direct monthly basis*) directly to the Applicant, unless written notification from the Applicant is received stating cancellation of coverage is desired.
 - The termination of the List Billing Agreement, or adjustments to the amount of the List Bill administration fee, may occur upon 30-day prior written notice to the Third Party.
 - The insurance applied for is neither intended nor anticipated to be an employer-sponsored health insurance plan as defined by state and/or federal law.
 - Any premium refunds that may be due will not be sent to me directly, but rather, will be credited to the Third Party List Bill account.

This is an important agreement. You should read it carefully and understand it before signing below.

Applicant Name

Third Party Name

Applicant Signature

Date

* Applicant may request monthly automatic bank draft, credit card payment, or direct billing options.