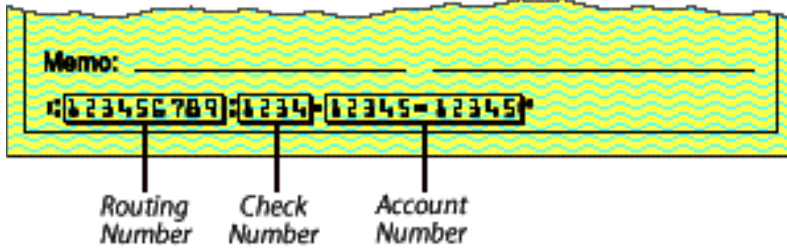




AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

- 1. Complete and sign the authorization form
- 2. Attach a copy of a VOIDED check from the account to be used
- 3. Fax to ODS at 503-243-3949 Attn: Indv.Mktg

THIS REQUEST IS:
NEW CHANGE



Name of Applicant _____ SSN _____

Initial Premium Payment
 Complete and authorize below for the bank deduction for your initial premium payment
 Account Holder _____
 Bank Name _____
 Bank Routing # _____ Account # _____

Recurring Premium Payment – please choose one of the three options
 1. _____ Continued draft _____ Same Bank _____ Different Bank (indicated below)
 2. _____ Direct Bill Monthly (add \$2 per month administrative fee)
 3. _____ Direct Bill Quarterly
 Account Holder _____
 Bank Name _____
 Bank Routing # _____ Account # _____

I (or we if this is a joint account) authorize ODS to charge my (our checking account) for monthly insurance premium for the above individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank and reasonable chance to act upon it. I can stop payment by notifying my bank before my account is charged.

Initial payment authorized by: _____
(signature of account holder)

Recurring payment authorized by: _____
(signature of account holder)

Authorizing payment does not guarantee coverage. The first month or quarterly premium amount will not be credited to your account until your application for individual health insurance coverage has been approved by ODS Underwriting. You will be notified in writing of your application status no later than 60 days from receipt. If you application is approved, the coverage effective date will be the 1st day of the month following approval. If your application is not approved, you will be notified in writing, and your accounted will not be debited.