Group Term Life Application

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ***ESUAA Group Insurance Program, P.O. Box 14533, Des Moines, IA 50306, or call 1-888-560-2586, or email customerservice.service@getamba.com.***

Emporia State University Alumni Association **Policy No. GL-66816-8**

1. TELL US ABOUT YOURSELF

Alum's Information ***(complete this section only if applying for Alum coverage on this application):***

Name (Last, First, M.I.)			☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Spouse's Information ***(complete this section only if applying for Spouse coverage on this application):***

Name (Last, First, M.I.)	Name of Alum		☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Dependent Child(ren)'s Information ***(complete this section only if applying for Dependent Child(ren) on this application).***

Number of eligible children: ____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Address	City	State	Zip	Home/Cell Phone #

	Alum	**Spouse**
a.) Do you currently use or have you used tobacco or nicotine products in any form in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
b.) Are you currently working less than 30 hours per week at your regular occupation and place of business?	☐ Yes ☐ No	☐ Yes ☐ No
c.) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please explain:_____

2. SELECT YOUR COVERAGE

Alum Amount
- ☐ $500,000
- ☐ $250,000
- ☐ $100,000
- ☐ Other: $_____ *in $10,000 increments (Minimum: $10,000 Maximum: $500,000)*

Spouse Amount
- ☐ $500,000
- ☐ $250,000
- ☐ $100,000
- ☐ Other: $_____ *in $10,000 increments (Minimum: $10,000 Maximum: $500,000)*

Please select if you wish to include additional options with your coverage *(If AD&D is elected, benefit will match life amount):*

- ☐ Alum Accidental Death & Dismemberment
- ☐ Spouse Accidental Death & Dismemberment
- ☐ Dependent Child(ren) Coverage*
  - ☐ $10,000 ☐ $5,000

*If both Alum and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

3. PROVIDE YOUR HEALTH INFORMATION

Alum: **Height**_____ **ft.** _____ **in. Weight**_____ **lbs.** Spouse: **Height**_____ **ft.** _____ **in. Weight**_____ **lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Alum:_____ Spouse:_____

	Alum	Spouse
1.) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	☐ Yes ☐ No	☐ Yes ☐ No
2.) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack), sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?	☐ Yes ☐ No	☐ Yes ☐ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?	☐ Yes ☐ No	☐ Yes ☐ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?	☐ Yes ☐ No	☐ Yes ☐ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?	☐ Yes ☐ No	☐ Yes ☐ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?	☐ Yes ☐ No	☐ Yes ☐ No
3.) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?	☐ Yes ☐ No	☐ Yes ☐ No
4.) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
5.) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?	☐ Yes ☐ No	☐ Yes ☐ No
6.) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?	☐ Yes ☐ No	☐ Yes ☐ No
a. Alum's driver's license number and state of issue:_____		
b. Spouse's driver's license number and state of issue:_____		
7.) Have you ever applied for insurance that was declined, postponed or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
8.) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?	☐ Yes ☐ No	☐ Yes ☐ No

For every "Yes" answer to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Alum Coverage ***(complete this section only if applying for Alum coverage on this application)***

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

Beneficiary for Spouse Coverage ***(complete this section only if applying for Spouse coverage on this application)***

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

***(Choose only one. Option selected is applicable to all coverages approved through this application)*:**

☐ **Option 1:** **AUTOMATIC CHECK WITHDRAWAL REQUEST:** ☐ Monthly ☐ Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: _____ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

☐ **Option 2:** **DIRECT BILL:** ☐ Quarterly ☐ Semi-Annual ☐ Annual

Billing dates will begin after coverage is approved and initial premium has been received.

6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- **To the best of my knowledge and belief, the information I have provided is complete and correct.**
- **I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.**
- **I understand my coverage begins on the "effective date" assigned by the Company.**

Authorization and Acknowledgment - Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, pharmacy prescriptions or prescription records or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance 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 may subject such person to criminal and civil penalties, and denial of insurance benefits.

Alum's Signature (always required)	Date	Spouse's Signature (if applying)	Date

Owner of Alum Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.)	Date of Birth (MM/DD/YYYY)	Social Security Number		
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature			Date	

Owner of Spouse Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.)	Date of Birth (MM/DD/YYYY)	Social Security Number		
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature			Date	

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ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, LLC., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, LLC, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, LLC.

We or our reinsurers may make brief reports to MIB, LLC (hereafter "MIB"). The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

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Alumni Group Term Life Insurance Plan

With up to $500,000 of coverage available

Available to you and your spouse with these additional features:

- Accelerated Benefits
- Coverage available 24 hours a day, seven days a week, anywhere in the world
- Coverage extends to age 75
- And much more!

Why apply for Alumni Group Term Life Insurance through the Emporia State University Alumni Association?

To help protect your loved ones from financial hardship ... the answer is that simple.

Perhaps you already have some life insurance. Chances are, you probably don't have enough. As a general guideline, you should have approximately FIVE TO EIGHT TIMES your annual income. If you have young children or heavy financial responsibilities, you may need even more.

Members of the Emporia State University Alumni Association family are eligible to apply for up to $500,000 in economical Group Term Life Insurance. The group buying power of your Alumni Association keeps your premiums economical and provides coverage at an affordable cost.

This Group Life Insurance could be used to:

- Help support your family for many years
- Help provide for your children's education
- Help pay off debts such as mortgage, car loan, charge accounts and other financial obligations

Up to $500,000 in Term Life Insurance for you and your spouse...

You and your spouse (if you are married) are each eligible to apply for up to $500,000 in $10,000 units of Alumni Group Term Life Insurance, subject to approval by the insurance company, as long as you are under age 65. The amount of insurance for a Spouse can be no more than the Member's amount.

Cover your children: You can also insure all of your eligible children. Just one monthly premium of $1.50 covers all children for $1,000 (ages 14 days to 6 months) and $10,000 (ages 6 months to 21 years of age; unless they are full time students when they can be covered to 25 years of age). Child coverage of $500/$5,000 is also available for $.75 per month.

Worldwide Coverage

This coverage will follow you anywhere in the world… no matter where you are. Benefits are payable for death for any reason, except suicide in the first two years of coverage (or increase in coverage).
The Accelerated Life and AD&D benefits are subject to additional exclusions.

Your Choice of Beneficiary

Choose anyone you wish to be your beneficiary. You may change your beneficiary at any time by writing to the Insurance Administrator. Claim payments are made promptly upon proof of death.

Conversion Rights Guaranteed

At any age prior to age 75, you have the right to convert your group term coverage to an individual whole life policy then being offered by the insurance company, without evidence of insurability and regardless of your physical condition (subject to policy provisions). Your dependents may convert when you do, or upon your death. Your children may also convert when they reach age 21, marry or cease dependency, whichever comes first.

Future Coverage Assured

Your coverage under this Plan cannot be cancelled or reduced due to health problems which may develop later. Your life insurance coverage is renewable (through age 74) and cannot be cancelled by the insurance company as long as you pay your premiums, and the group policy remains in force.

Accelerated Benefits

You may receive a portion of your life insurance benefit before death if you are diagnosed with a terminal condition as defined in the certificate. This can be a helpful way to pay for medical and hospital expenses associated with a serious medical illness. Receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.

Accidental Death & Dismemberment Insurance Option

You and your Spouse can elect the same level of Accidental Death & Dismemberment (AD&D) coverage as for Life Insurance coverage ($10,000-$500,000 in $10,000 increments). The Spouse may not be covered for benefits that are greater than 100% of the Member's benefits.

The additional rate for this benefit is $0.40 per $10,000 of benefit per month. Rates are guaranteed to December 31, 2023.

ReliaStar Life pays this benefit if you lose your life, limb, or sight due to a covered accident. All of the following conditions must be met:

- You are covered for AD&D Insurance on the date of the accident
- The loss occurs within 180 days of the date of the accident.
- The cause of the loss is not excluded.

Non-Tobacco User Discount

If you haven't used any tobacco products in the last 12 months, you qualify for rates even lower than the regular group rates.

Renewable to Age 75

You may continue your coverage to age 75 assuming you pay your premiums when due, and the group policy remains in force. Benefits will reduce to the lesser of 50% or $50,000 upon attainment of age 70. Premium will be based on the Age 70 rate.

Convenient Payment Options

Automatic Monthly Check Withdrawal: Have your premiums deducted automatically from your checking account on a monthly basis. This saves time spent tracking due dates and sending checks.

Semi-Annual Direct Bill: Have your premiums billed to you directly on a semi-annual basis (subject to $2.00 billing fee).

Here's How to Apply

1. Complete, date and sign the enclosed Application; be sure to indicate the amount of coverage you are applying for.
2. Indicate your billing preference. If you select Automatic Monthly Check Withdrawal, you must complete the enclosed Automatic Monthly Check Withdrawal request form and include a check for your first monthly premium as well as a blank voided check. If you select Semi-Annual Direct Bill, include a check for your first semi-annual premium.
3. Mail your Application(s) to:
   ESUAA Group Insurance Program
   P.O Box 14533
   Des Moines, IA 50306

Satisfaction Guaranteed!

If you are not completely satisfied with the terms of your coverage after you receive your Certificate of Insurance, return it within 30 days. Provided no claims have been submitted or paid, your money will be refunded in full. No questions asked!

This Plan Is Administered by:

Association Member Benefits Advisors, LLC
P.O. Box 14533
Des Moines, IA 50306

Call: 1-888-560-2586
Email: customerservice.service@getamba.com
Web: www.esuaa.alumniplans.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

Group Term Life Insurance Underwritten by:
ReliaStar Life Insurance Company
Minneapolis, MN

All applicants accepted under this program will receive a Certificate of Group Life Insurance from the insurance company. This program may not be available to residents of all states. It has been designed so that you may add to your existing life insurance coverage and is not intended to replace any current life insurance coverage now in force.

In some instances a physical exam may be requested depending on age, amount of coverage and answers to the questions on the application. For coverage of over $100,000 a blood profile will be required and, depending on age, an exam may be required. The cost of the exam will be paid for by the insurance company.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Product provisions may vary by state. Policy form LP08GP.

This is paid endorsement. Alumni Group Insurance Trust receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

LI1037P-32682

RATES

Member/Spouse Non-tobacco <$100,000			
Age	Per $10,000/ Semi-Annual	Monthly	$50,000/ Mo.
16-19	3.68	0.0613	3.07
20-24	3.68	0.0613	3.07
25-29	3.68	0.0613	3.07
30-34	4.08	0.0680	3.40
35-39	5.68	0.0947	4.73
40-44	9.36	0.1560	7.80
45-49	14.80	0.2467	12.33
50-54	23.44	0.3907	19.53
55-59	37.28	0.6213	31.07
60-64	57.28	0.9547	47.73
65-69*	88.76	1.4793	73.97
70-74*	137.10	2.2850	114.25

Member/Spouse Non-tobacco $100,000+			
Age	Per $10,000/ Semi-Annual	Monthly	$100,000/ Mo.
16-19	2.98	0.050	4.97
20-24	2.98	0.050	4.97
25-29	2.98	0.050	4.97
30-34	3.30	0.055	5.50
35-39	4.60	0.077	7.67
40-44	7.58	0.112	12.63
45-49	11.99	0.200	19.98
50-54	19.00	0.317	31.67
55-59	30.20	0.503	50.33
60-64	46.40	0.773	77.33
65-69*	71.85	1.198	119.75
70-74*	111.05	2.851	185.08

Member/Spouse Tobacco <$100,000			
Age	Per $10,000/ Semi-Annual	Monthly	$50,000/ Mo.
16-19	5.36	0.089	4.47
20-24	6.16	0.103	5.13
25-29	6.48	0.108	5.40
30-34	7.04	0.117	5.87
35-39	9.04	0.151	7.53
40-44	13.36	0.223	11.13
45-49	20.56	0.343	17.13
50-54	32.00	0.533	26.67
55-59	49.76	0.829	41.47
60-64	74.88	1.248	62.40
65-69*	113.52	1.892	94.60
70-74*	175.40	2.923	146.17

Member/Spouse Tobacco $100,000+			
Age	Per $10,000/ Semi-Annual	Monthly	$100,000/ Mo.
16-19	4.32	0.072	7.20
20-24	5.04	0.084	8.40
25-29	5.20	0.087	8.67
30-34	5.76	0.096	9.60
35-39	7.36	0.112	12.27
40-44	10.88	0.181	18.13
45-49	16.80	0.280	28.00
50-54	26.00	0.433	43.33
55-59	40.56	0.676	67.60
60-64	60.96	1.016	101.60
65-69*	92.40	1.540	154.00
70-74*	142.80	2.380	238.00

Rates are guaranteed to December 31, 2023 (unless you experience an age rated change).

*Rates for ages 65-74 are for renewal only. Coverage not available to new applicants age 65 and older.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.