

Employer Application for Small Business



To avoid processing delays, please make sure you:

- 1 Answer all questions completely and accurately.
- 2 Complete and submit the Product and Benefit Selection Form.
- 3 Submit the most recent billing statement listing those currently insured and current status.
- 4 Submit most recent wage and tax information.
- 5 Include a deposit check for the first month's premium.
- 6 **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Address	Tax ID
---------	--------

City	State	Zip Code	Names of Owners/Partners (if applicable)
------	-------	----------	--

Contact Person	Telephone	Fax	Email Address
----------------	-----------	-----	---------------

Billing Address (If Different)	# of Years in Business
--------------------------------	------------------------

Organization Type	Nature of Business	Industry (SIC) Code
<input type="checkbox"/> Partnership <input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> LLC/LLP <input type="checkbox"/> Ind. Contractor <input type="checkbox"/> Non-Profit <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other _____		

Multi-Location Group	# Locations	Address(es) (or list on additional sheet of paper)
<input type="checkbox"/> Yes <input type="checkbox"/> No		

# Hours per week to be eligible	Waiting Period for new hires	Waiting Period waived for initial enrollees
	<input type="checkbox"/> 1st of Policy Month following Date of Hire <input type="checkbox"/> 1st of Policy Month following ____ [months] [days] of employment <input type="checkbox"/> Date of Hire (no waiting period) <input type="checkbox"/> ____ [months] [days] of employment following Date of Hire	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have Worker's Comp	Worker's Comp Carrier Name	Names of Owners/Partners not covered by Workers' Comp:
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Names of Persons currently on COBRA/Continuation:	Classes Excluded:
<input type="checkbox"/> See Attached List <input type="checkbox"/> None	<input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Management <input type="checkbox"/> Non-Owners

Has the Group been insured by UnitedHealthcare in the last 12 months: Yes No If yes, date coverage terminated: / /

Name of Current Medical Carrier	Begin Date ____/____/____	Name of Current Dental Carrier	Begin Date ____/____/____
<input type="checkbox"/> None	End Date ____/____/____	<input type="checkbox"/> None	End Date ____/____/____

Do you currently offer or intend to offer a Health Reimbursement Account plan and/or voluntary or involuntary supplemental insurance (e.g., critical illness, hospital income, deductible reimbursement, etc.) policy along side this UnitedHealthcare medical plan?
 Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
 HRA Yes No If yes, please identify type: Definity Standard HRA Definity Select HRA Other Administrator HRA
 Supplemental Insurance Yes No
 If you answered "Yes" for HRA, you must choose from the list of Definity HRA-eligible benefit plans as shown to you by your broker or agent.
 Other plans are not eligible for pairing with a Health Reimbursement Account.

Coverage Provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Colorado, Inc.
 Dental coverage provided by United HealthCare Insurance Company or United HealthCare of Colorado, Inc.
 Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
 Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Participation	# Applying for:	# Waiving for:	Contribution	Employer %	Employee%	Employer % for Dep
# Full Time Employees	Medical	Medical	Medical			
# Part Time Employees	Life	Life	Life			
# Ineligible Employees	Dental	Dental	Dental			
Total # Employees	Vision	Vision	Vision			
	Other	Other	Other			

Questions Regarding Group Size

<input type="checkbox"/> COBRA <input type="checkbox"/> St. Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact their legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each.
For 10-50 Size Group <input type="checkbox"/> age-banded rates <input type="checkbox"/> composite rates	Groups with 10-50 employees may choose composite rates and/or age-banded rates; composite rates will be provided unless age-banded rates are requested. Groups with nine or less eligible employees will be provided age-banded rates.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Any person who knowingly and 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.

UnitedHealthcare disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to <http://www.uhc.com> and click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date
----------------------------	-------	------

Commission Information

Writing Broker Name Steven J. Roper	Writing Broker SSN 326521705	Is the Broker appointed with UHC? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Commissions Payable to: Roper Insurance	Payee Code	CRID Code	Tax ID# 841590836
Street Address 116 Inverness Dr East #265	City Englewood	State CO	Zip Code 80112
Broker Phone # 303-721-1145	Broker Email Address uw@roperinsurance.com	Broker Fax Number 303-721-1085	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	Broker Signature	Date
--	------------------	------

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

Admin Kit

Send Admin Kit To:	Address
--------------------	---------

Product and Benefit Selection Form for Colorado Small Business

General Information

Group Name _____

Agent Name _____

Please Indicate Billing Preference. Check all that apply.

Paper billing Electronic billing (Note: Hard copies of the bill may still be printed out from www.employereservices.com)

Please Indicate Medical Plan Selection.

Single Site Multi-Site Other Locations _____

If enrolling in a UnitedHealthcare Multi-ChoiceSM package, please select the package and Rx plan being purchased. Then, indicate which plans within the package are being offered to employees. If enrolling in a stand-alone plan, write the plan code in the space provided.

NOTE: You may only select one Multi-Choice package or one stand-alone medical plan.

UnitedHealthcare Multi-Choice Packages:

Multi-Choice CO01 (CO MC Pkg 1)

Plan Code	Plan Category	Description	Plan Code	Plan Category	Description
<input type="checkbox"/> C2-K	Balanced	25/500/80%	<input type="checkbox"/> Q3-P	Definity HSA	2850/100%
<input type="checkbox"/> C2-L	Balanced	25/1000/80%	<input type="checkbox"/> Q3-Q	Definity HSA	3500/100%
<input type="checkbox"/> L6-W	Balanced	25/1000/80%	<input type="checkbox"/> Q3-R	Definity HSA	5000/100%
<input type="checkbox"/> C2-S	Balanced	30/1000/70%	<input type="checkbox"/> 11-Z	Definity HRA	3000/80%
<input type="checkbox"/> C2-M	Balanced	25/1500/80%	<input type="checkbox"/> Q4-T	Definity HRA	30/5000/100%
<input type="checkbox"/> C2-Q	Balanced	25/2000/70%	<input type="checkbox"/> C8-1	\$250 Direct	25/1000/80%
<input type="checkbox"/> C2-U	Balanced	30/2000/70%	<input type="checkbox"/> C8-2	\$250 Direct	30/1000/80%
<input type="checkbox"/> C2-X	Balanced 100	30/3000/100%	<input type="checkbox"/> C8-4	\$250 Direct	30/1500/80%
<input type="checkbox"/> C2-V	Balanced	30/3000/70%	<input type="checkbox"/> C8-6	\$250 Direct	30/2000/80%
<input type="checkbox"/> C2-Z	Balanced 100	30/5000/100%	<input type="checkbox"/> C7-2	\$250 Direct	30/2000/80%
<input type="checkbox"/> Q3-O	Definity HSA	2000/100%	<input type="checkbox"/> C8-7	\$250 Direct	35/2500/70%
<input type="checkbox"/> Q3-M	Definity HSA	2000/80%	<input type="checkbox"/> Y3-C	EDGE	30/2000/100%

Multi-Choice MSEC1 (MSEC MC)

Plan Code	Plan Category	Description
<input type="checkbox"/> L6-V	Balanced	25/1000/80%
<input type="checkbox"/> C2-L	Balanced	25/1000/80%
<input type="checkbox"/> C2-M	Balanced	25/1500/80%
<input type="checkbox"/> D7-H	Definity HSA	2000/90%
<input type="checkbox"/> Q3-P	Definity HSA	2850/100%
<input type="checkbox"/> 11-W	Definity HRA	25/2000/80%
<input type="checkbox"/> C2-Z	Definity HRA	30/5000/100%
<input type="checkbox"/> C7-1	\$250 Direct	30/1000/80%
<input type="checkbox"/> C8-3	\$250 Direct	25/1500/80%
<input type="checkbox"/> D7-F	EDGE	30/2000/90%

Prescription (Rx) Benefit Plans (all non-HSA plans):

Select only one Rx plan.

All HSA Plans have Rx Plan H9 (10/30/50) included. C2-Q, C2-Z, C8-7 and Y3-C Plans are only available with Rx Plan DZ.

FP PE DZ OV OX

Single Plan Options.

Stand-Alone Medical Plan Code _____

Stand-Alone Prescription (Rx) Benefit Plan Code _____

Vision Plan Code _____

Dental Plan Code(s)* _____

*Please attach prior medical and dental carrier bills

Deductible Administration

Calendar Year (from January 1 to December 31)

Policy Year (from effective date to renewal date)

Group Name: _____

Please Indicate Life and AD&D Plan Selection.

Basic Life & AD&D Benefit Amount*

- \$15,000
- \$20,000
- \$25,000
- \$50,000
- \$75,000
- \$100,000
- Other \$ _____

Multiple of Salary

- 1 X Annual Salary to \$ _____
- 2 X Annual Salary to \$ _____

* Maximum & Guarantee Issue 2–5 enrolled employees – \$25,000
6–19 enrolled employees – \$50,000
20–50 enrolled employees – \$100,000

Dependent Life Benefit Amount

- | | |
|--|---------|
| <input type="checkbox"/> Spouse | \$7,500 |
| <input type="checkbox"/> Child (6 months+) | \$3,750 |
| <input type="checkbox"/> Spouse | \$4,000 |
| <input type="checkbox"/> Child (6 months+) | \$2,000 |
| <input type="checkbox"/> Spouse | \$2,000 |
| <input type="checkbox"/> Child (6 months+) | \$1,000 |

Other Notes

The answers provided in this Product and Benefit Selection Form are accurate and complete to the best of my knowledge and belief, and the Insurer shall rely and act upon them accordingly.

This Product and Benefit Selection Form must accompany the Employer Application for Small Business.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature

Employer Signature	Title	Date
--------------------	-------	------

I authorize any required premium contributions to be deducted from earnings.

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

CONFIDENTIALITY

Make sure your employer has completed the “To be completed by the employer” section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.



Your Rights and Responsibilities

Important Information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at www.myuhc.com.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not

control nor do we have a right to control your physician's treatment or plan.

5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

Pre-Existing Conditions – This section does not apply to HMO in-network health services.

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan, that injury or sickness may be considered a pre-existing condition.

Under federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to six months from the above date. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth,

adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 90 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 90 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.

I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.

Scheduled Direct Debit Authorization Form

Enrollment Instructions

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.

STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Debit, I agree to and/or understand all of the following on behalf of my group:

It may take up to one month to establish this process. If a customer is overdue on a prior bill, a delinquency letter will be sent to the customer, and must be paid to ensure the account is not cancelled prior to the process being set up.

I authorize UnitedHealthcare to debit my group's checking or savings account for all monthly charges for coverage.

I ensure sufficient funds are in my group's checking or savings account to cover my premium invoice.

If the necessary funds are not on deposit in the account at the beginning of the month, my group's coverage may be subject to termination under the terms stated in the contract with UnitedHealthcare. Also, my group may be subject to additional fees incurred by UnitedHealthcare subsequent to the termination date as a result of insufficient funds.

I will promptly notify UnitedHealthcare of any change to my group's checking or savings account. If a change occurs it is my responsibility to provide UnitedHealthcare with the current information.

AUTHORIZATION

I hereby authorize UnitedHealthcare to initiate debits (payments) to the financial institution indicated below for the purpose of paying my group's monthly bill. This financial institution is authorized to debit my account. This authority is to remain in full force and effect until either my group revokes it by giving 30 days prior written notice to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above, or upon termination of my group's coverage with UnitedHealthcare. I have also read and, on behalf of my group, agree to the terms and conditions outlined above.

Authorized Signature

Date

Employer Name/Customer Name/Policy Name

Employer Email Address

Customer Number and Bill Group(s)

Name of Your Financial Institution and Location State

Phone Number of Financial Institution

Transit / American Bankers Association #

Number can be found in lower left corner of your check

Account Number to Debit

Debits to your account will be made on the beginning of each month

Employer eServices

Becoming a UnitedHealthcare customer has its privileges!

As a UnitedHealthcare customer, the group contact listed on the Employer Group Application will automatically be enrolled in Employer eServices and emailed a User ID and Password. The Employer eServices Web site provides easy access to benefit administration, with 24 hour convenience to make benefit management simpler, easier and better!

With Employer eServices, you have real-time administration to:

- Verify eligibility
- Review enrollment information
- Add employees and dependents
- Change eligibility
- Reinstate employees
- Terminate employees
- Request employee ID cards
- Select or Change Primary Care Physician (as required by plan)
- Delegate benefits administration work to additional staff

Once you receive your User ID and Password, simply go to www.employereservices.com.

We believe in putting the power of information into the hands of our customers!

■ Yes, I am interested in signing up for Employer eServices. (Please complete information below)

- I am unable to sign up for Employer eServices. (Please complete name and address section)
- I don't have a computer or Internet access.
 My hardware/software is not compatible.
- I use a third party vendor.
 Other _____

Your Name: _____

Phone Number: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Group Number: _____ (this number may be found on your company's UnitedHealthcare member ID card)

Hardware/Software Requirements

- Processor – High-speed processor (equivalent of Pentium P266 or greater recommended)
- Memory – 64MB or greater (128 MB recommended)
- OS – Windows 95, NT or greater
- Browser – Internet Explorer 5 or greater, or Netscape Communicator 4.51 - 4.77

List the Employer eServices Users

Please insert an "X" for access needed for each user

Users First & Last Name (List Main User/Primary Contact First)	Phone Number (include area code)	E-Mail Address	Eligibility Inquiry and Update	Online Billing
1)			<input checked="" type="checkbox"/>	<input type="checkbox"/>
2)			<input checked="" type="checkbox"/>	<input type="checkbox"/>
3)			<input checked="" type="checkbox"/>	<input type="checkbox"/>
4)			<input checked="" type="checkbox"/>	<input type="checkbox"/>
5)			<input checked="" type="checkbox"/>	<input type="checkbox"/>

Check here if interested in Online Bill Payment

Attention: If you check Online Billing, you will no longer receive paper bills. Simply print the invoice from your computer and mail it in.

Please submit to your UnitedHealthcare representative:

Name: _____ Fax: _____

Employer eServices Scheduled Direct Debit

Sign up for UnitedHealthcare's Scheduled Direct Debit and have your premium payments automatically deducted from your bank account.

If you're looking for new and better ways to help organize, streamline and generally make your job easier, there's no better place to start than with UnitedHealthcare's Scheduled Direct Debit.

That's because Scheduled Direct Debit is a safe, convenient and automatic way to pay your monthly insurance premiums.

All you do is sign up, then every month we automatically deduct your premium from your company's bank account.

Even better, Scheduled Direct Debit helps you better organize your payment records, streamlines your monthly invoice payment process and frees you up to get on with the business of your business.

Enroll today in UnitedHealthcare's Scheduled Direct Debit program. Just fill in the simple form on the reverse side and return it to us. Do it today. And give yourself one less thing to worry about.

Scheduled Direct Debit:

- ▶ Lets you pay your premium at the same time each month.
- ▶ Provides predictable cash outflow.
- ▶ Gives you a consistent process for your premium payment.
- ▶ Provides an accurate record of your payment listed right on your bank statement.
- ▶ Means you'll never have to worry about missing an invoice or a deadline again. Everything's taken care of. Automatically.

Get organized.

Get streamlined.

Get UnitedHealthcare's

Scheduled Direct Debit.

