AUTOPAY AUTHORIZATION FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

SAVE THE HASSLE OF WRITING US A CHECK. PAY YOUR PREMIUMS THE CONVENIENT WAY WITH AUTOPAY!

With Autopay, there's no bill to keep track of. No check to write. And nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account. Just complete and sign this authorization form. Email, mail, or fax it to us, and we'll handle all the details with your bank.

Complete and sign form and submit to us:
By Email: **AUTOPAY@AZBLUE.COM** By Fax: **602-864-4041** By Mail: Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

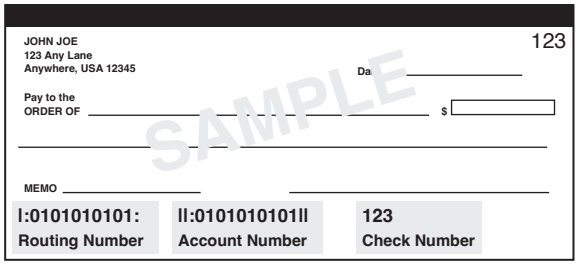
Note: If you have both a medical and dental policy with us, you are only able to set up Autopay with one account for both premiums to draft from.

MEMBER NAME	**MEMBER ID**

PERSON TO BE BILLED				
Last Name	First Name	Middle Initial	Daytime Phone	
Address	City		State	ZIP Code
Please Draft My:		Routing Transit Number	Account Number	
☐ Checking Account ☐ Savings Account				

IMPORTANT: REMEMBER TO SIGN THE AUTHORIZATION BELOW.

I authorize Blue Cross® Blue Shield® of Arizona (BCBSAZ) to start an automatic periodic charge to my checking or savings account as noted on this form. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.



I want this charge to continue automatically until I write BCBSAZ telling them to discontinue my Autopay service. I agree to allow a reasonable time for discontinuance of Autopay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Autopay withdrawals.

I understand BCBSAZ and my financial institution have the right to discontinue this service if either elects to do so.

I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month or twice the amount the following month. My BCBSAZ coverage will be terminated if there are insufficient funds in two consecutive drafts.

*******REMINDER: PRIOR TO YOUR FIRST DRAFT ANY OUTSTANDING BILLED AMOUNT WILL BE DEDUCTED********

I HAVE READ AND AGREE TO ABIDE BY THE AUTOPAY CONDITIONS AS OUTLINED ON THIS AUTHORIZATION FORM.

Authorized signature on Account **Date**

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