Blue Cross of Idaho

Authorization Agreement for Automatic Withdrawal

Name of CUSTOMER *(please print)* _____

Name of responsible party *(if other than customer)* _____

CUSTOMER Identification Number _____

First Month's Premium
You may pay your first month's premium by automatic withdrawal from your checking or savings account.

☐ Check here if you wish to have your first month's premium payment withdrawn from your account.
Please attach a cancelled check and complete the account information below.

Subsequent Month's Premium
You may pay your monthly premium either by monthly billing statement or monthly automatic withdrawal from your financial institution. Please choose one:

☐ **Monthly Billing Statement**

☐ **Monthly Automatic Withdrawal** You can sign up for automatic withdrawal on our website, ***bcidaho.com.***

Select the day of the month you want Blue Cross of Idaho to withdraw premiums from your account and we will draft payments from your account on that date or the next available business day. If you don't make a selection, withdrawals default to the 28th day of every month. It may take up to two months before the system automatically withdraws funds from your account, but once established, the first payment will not include any previous balance. You may receive a statement for any previous balance due.

☐ Please withdraw premium payments on the **28th day of the month**

☐ Please withdraw premium payments on the **5th day of the month**

☐ Please withdraw premium payments on the **7th day of the month**

Authorization Agreement for Automatic Withdrawal
For automatic withdrawal, please read and complete the account information below, and attach a voided check.

I/we authorize and request Blue Cross of Idaho to obtain payment for premiums to Blue Cross of Idaho as selected above by withdrawing the funds from my/our account at the financial institution named below. I/we authorize and request the financial institution to accept any withdrawals initiated by Blue Cross of Idaho. Blue Cross of Idaho assumes full responsibility for correctly informing the financial institution of the specific amount of each deduction. I/we may terminate this agreement at any time by notifying Blue Cross of Idaho or the financial institution in writing.

Termination will become effective within a reasonable time after receipt of the written notice by Blue Cross of Idaho.

Fax completed form to 208-331-7582 or mail to Blue Cross of Idaho, ATTN: Meridian District Office, P.O. Box 7408, Boise, ID 83707.

BANK Name _____

BANK Address *(city, state)* _____

Signed _____ Date _____

Signed _____ Date _____

☐ Checking Account ☐ Savings Account ☐ Other

⑆ ⑆

Transit Routing Number Account Number Information

An Independent Licensee of the Blue Cross and Blue Shield Association