



Illinois  
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**ezBlue**<sup>SM</sup>  
PAYMENT OPTION

**Authorization Agreement**

**Take these simple steps for hassle-free monthly premium payments:**

- Verify with your financial institution that it can accept automated electronic withdrawals.
- Complete, sign and return this authorization form.
- If submitting by fax, please fax this form to **888-235-2949**.
- If submitting this form by mail, please use this address:

**Medicare Supplement Membership  
P.O. Box 3004  
Naperville, IL 60566**

If you have any questions about this program, please call our Customer Service Department toll-free at **1-800-624-1723**.

**AGREEMENT**

I request and authorize Blue Cross and Blue Shield (BCBS) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This authorization will remain in effect until I notify BCBS or the Financial Institution in writing to terminate and BCBS or the Financial Institution has a reasonable time to act on the termination.

**Please complete the following - Print or Type information**

Deduct ongoing monthly premium payments from my designated checking or savings account. If the withdrawal date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. (Please note that coverage cannot be issued until the first month of premium has been received in our office, unless you have authorized BCBS to deduct the initial payment upon receipt of your application).

BCBS Member ID: \_\_\_\_\_

Name of Member: \_\_\_\_\_

Name of Depositor(s) if other than the member: \_\_\_\_\_

Phone number of Member/Depositor: \_\_\_\_\_

Name of Bank, City and State  
where account is authorized: \_\_\_\_\_

Please check one:    Checking Account    Savings Account

Bank Transit Number: \_\_\_\_\_

Depositor's Account Number: \_\_\_\_\_

**I have read and accept the above agreement.**

**Please continue to pay your premiums by check or money order until you receive a confirmation letter from us stating the date automatic payments will begin.**

Depositor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

