

FINANCIAL INSTITUTION DEBIT AUTHORIZATION



BlueCross BlueShield
of Oklahoma

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 authorized form.
- If submitting by fax, please return this form to: 1-888-223-1988.
- If submitting this form by mail, please also include a blank check marked VOID or a savings deposit slip for the account from which funds are to be withdrawn and then mail to the address below:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3236
Naperville, IL 60566-7236

If you have any questions about this program, please call our Customer Service Department toll-free at 1-866-520-2507.

PLEASE ENSURE ADEQUATE FUNDS ARE AVAILABLE AT THE TIME OF APPLICATION. BLUE CROSS AND BLUE SHIELD OF OKLAHOMA IS NOT RESPONSIBLE FOR FEES INCURRED DUE TO INSUFFICIENT FUNDS.

REMINDER

Please attach your VOIDED
CHECK (personal checking)
or savings deposit slip.

Your Name
Your Address
Your City, State & Zip

Pay to the
Order of _____ \$ _____ Dollars

DEPOSITORY BANK OR BRANCH NAME
BANK ADDRESS _____

⑆ 234 56 78 ⑆ 234 56 0 ⑆ 00 ⑆

AUTHORIZATION AGREEMENT

I request and authorize Blue Cross and Blue Shield of Oklahoma (BCBSOK) 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. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer-sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and BCBSOK reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Blue Cross and Blue Shield of Oklahoma by telephone prior to a scheduled withdrawal date.

PLEASE COMPLETE THE FOLLOWING – PRINT OR TYPE INFORMATION

- Yes No . . . Upon receipt of my application, please deduct the premiums due for the entire length of coverage designated, in one lump sum.
- Yes No . . . Upon receipt of my application, please deduct the first month's premium payment from my checking or savings account (if not submitted separately) and ongoing monthly premium payments from my checking or savings account on the monthly premium due date. If the draft date falls on a non-business day or holiday, the premium payment will be deducted from my account on the next business day.

Once approved, Blue Transitions premiums are non-refundable.

IDENTIFICATION NUMBER (on your I.D. card) / APPLICANT'S SOCIAL SECURITY NUMBER: _____

PLEASE CHECK ONE: Checking Account Savings Account

NAME OF APPLICANT: _____

NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT: _____

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED: _____

ADDRESS OF BANK: _____

BANK TRANSIT NUMBER: _____ DEPOSITOR'S ACCOUNT NUMBER: _____

I HAVE READ AND ACCEPT THE ABOVE AGREEMENT.

DEPOSITOR'S SIGNATURE: X _____ DATE: _____

RELATIONSHIP TO APPLICANT: _____