

 **Blue Cross MedicareRx (PDP)SM**
Automatic Premium Payment Program
Authorization Agreement

Take these three simple steps to hassle-free monthly premium payments:

- Complete and sign this authorization agreement.
- Verify with your financial institution that they can accept automated electronic withdrawals.
- Return a blank check marked VOID for the account from which funds are to be withdrawn, along with this authorization form, to the following address:

Blue Cross MedicareRx (PDP)
c/o Member Services
P.O. Box 3897
Scranton, PA 18505

Your payments will be deducted on approximately the 4th of each month.

AGREEMENT

I, as account holder, hereby authorize HCSC Insurance Services Company (HISC) to initiate withdrawals on a monthly basis from my account at the financial institution named in this authorization for payment of monthly Blue Cross MedicareRxSM insurance premium due for the named policyholder; and, I authorize the financial institution to charge such withdrawals to my account.

A draft shall be drawn each month on or about the premium due date of the policy/contract. As the account holder, by signing below, I also certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction, that the company is not paying any portion of the premium for this subscriber, either directly, or through reimbursement, and that the employer/company is not deducting any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code. I understand that both the financial institution and HISC reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program (except on individual temporary contracts) at any time with at least 10 days advance notice to HISC by telephone prior to a scheduled withdrawal date.

I am authorizing my insurance premium due for this Blue Cross MedicareRx coverage, be paid as described in this agreement and agree that if any withdrawal is dishonored, the premium payment for such withdrawal will be considered in default. I also authorize the disclosure of my policy identification/group numbers and any other necessary personal information on the financial institution's statements to identify to the account holder named for whom withdrawals are being made.

Blue Cross MedicareRx is a prescription drug plan provided by HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.

PLEASE COMPLETE THE FOLLOWING • Print or type information

Yes, I elect to have my insurance premium paid monthly through the Automatic Premium Payment Program.

Member Name: _____

Group Number: _____ Member ID: _____

Address: _____

City: _____ State _____ ZIP: _____ Phone #: _____

Account Holder Name(s): _____ Phone #: _____

Account Holder Address: _____

Full Name of Bank or Financial Institution:

Bank Account Number: _____ Checking OR Savings

Routing Number: _____

I have read and accept the above agreement.

Member Signature: _____

Account Holder Signature(s) _____

(if different from Member)



**BlueCross BlueShield
of Oklahoma**

Blue Cross and Blue Shield of Oklahoma complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Oklahoma does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Oklahoma:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Oklahoma has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-285-2249 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-285-2249 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-285-2249 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-285-2249 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-285-2249 (TTY: 711) 번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-285-2249 (TTY: 711).

ملحوظ: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم 1-888-285-2249 (رقم هاتف الصم والبكم: 711).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-888-285-2249 (TTY: 711) သို့ ခေါ်ဆိုပါ။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-285-2249 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-285-2249 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-285-2249 (ATS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-285-2249 (TTY: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-285-2249 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-888-285-2249 (TTY: 711).

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-888-285-2249 (TTY: 711)

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی به صورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1-888-285-2249 (TTY: 711).