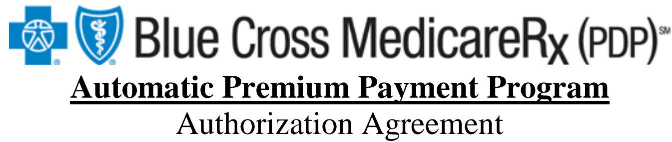

Automatic Premium Payment Program

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- Return a blank check marked VOID for the account from which funds are to be withdrawn, along with this authorization form, to the following address: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 MedicareRx[SM] 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.

Prescription drug plans 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 plans 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)