

Medicare Supplement automatic payment form

Say goodbye to paying by check with our simple automatic payment options

What is Easy\$Pay?

Easy\$PaySM is a simple, convenient way to pay your monthly Medicare Supplement plan dues without having to write a check. Just authorize Blue Shield to automatically withdraw your monthly dues from your personal checking or savings account, and you save \$2 per month on your plan dues.

How does credit card payment work?

With credit card payment, you simply authorize Blue Shield to charge your monthly or quarterly dues to your Visa or MasterCard.

Many automatic advantages

By using our automatic payment options, you won't ever be concerned about paying on time again. There is no check to write, no postage to pay, and it is free.

How to get started

Complete the attached authorization form, and send it back in the enclosed postage-paid envelope.

To use Easy\$Pay:

Complete the form, and enclose a check for your first month's dues along with a blank check or deposit slip marked "void." This will be used as a record of your account number, your bank's code, and other necessary information. If you prefer not to attach a voided check or deposit slip, you must provide your bank account number and the routing/transit number of your financial institution (see illustration below).

Mary Jane Blue 123 First St. Anytown, CA 99999	3025
Pay to Order of	20
Any Bank San Francisco Main Office P.O. Box 8944 San Francisco, CA 94126	Dollars
Memo	
032056884 9 8707228001 0233	

Bank Account Number

Bank Routing/Transit Number

To use your Visa or MasterCard:

To charge your monthly or quarterly dues to your credit card, just complete the form on the next page.

It may take up to a month to process your application, so please continue to send in your monthly dues until you receive notice from Blue Shield that your automatic payment has been accepted.

Easy\$Pay is a service mark of Blue Shield of California.

Automatic Payment Authorization Form

Medicare Supplement plans

- I am:** a new automatic payment applicant
 a current automatic payment user reporting a change in my credit card, bank or account number (please note this change requires 30 days for processing)

Subscriber information

Subscriber name _____ Subscriber number _____
Mailing address _____ Daytime phone number _____
City _____ State _____ ZIP _____

Easy\$Pay – Checking or savings account debits

Debit date: 1st of month 15th of month

Note: If you're requesting Easy\$Pay and you're sending a voided check or deposit slip, you don't need to complete the following.

Type of account: Checking Savings

Bank routing/transfer number _____
Bank account number _____
Name of financial institution _____ Branch telephone number _____
Name(s) on bank account _____
Branch address _____
City _____ State _____ ZIP _____

Credit card payments

Please note: The \$2 savings only applies to the Easy\$Pay payments and does not apply to credit card payments.

Type of account: Visa MasterCard
Payment frequency: Monthly charge Quarterly charge

Credit card charge date must be on the first of the month.

Cardholder name _____
Cardholder billing address _____
City _____ State _____ ZIP _____
Credit card number _____ Expiration date (mm/yyyy) _____

Authorization and signature(s)

Automatic payment by debit from checking/savings account:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

Automatic payment by credit card:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge (and/or apply credits, if correcting errors to previous charges) the credit card identified on this form on the payment date and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I understand that charges may occur 1 to 2 days prior to the payment date indicated on this form. If the credit card transaction ever fails (e.g., over limit, expired), Blue Shield will mail a bill to me to my address on record and I will be responsible for making my payment by check or money order.

Notice to Change/Cancel Required:

I will continue to be debited/charged the amount of dues/premium owed until I cancel this automatic payment authorization upon at least 10 calendar days notice before a debit/charge, is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at (800) 248-2341. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form, and I acknowledge that I have received a copy of this form (if the bank account is a joint account, all account holders must sign). I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Signature _____ Print name _____
Social Security number _____ Date _____
Signature _____ Print name _____
Social Security number _____ Date _____

KEEP THIS SECTION FOR YOUR RECORDS

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Signature _____ Print name _____
Social Security number _____ Date _____
Signature _____ Print name _____
Social Security number _____ Date _____