

Please fill out the Automatic Debit Authorization Form and return it today.



### What is Automatic Debit?

**In a word:** *convenient*

Automatic Debit lets you pay your premiums automatically. Simply authorize us to withdraw the amount due from your checking account or to charge the premium to your major credit card. What's more, Automatic Debit allows you to automatically pay your premiums on a monthly basis. And, Automatic Debit is free.



840 First Street, NE  
Washington, DC 20065  
[www.carefirst.com](http://www.carefirst.com)

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# Automatic Debit Plan



*The way to pay your health insurance premiums...  
It's convenient and it's free!*

# Automatic Debit

## Five Good Reasons to Sign Up Now

- **Automatic Debit is convenient and saves you time and money.** You no longer have to write checks and pay for postage.
- **Automatic Debit helps you budget your health insurance premiums.** You can conveniently keep an eye on your budget and statements.
- **Automatic Debit provides excellent record keeping.** Your monthly bank or credit card statement helps keep track of all your premiums.
- **Automatic Debit gives you peace of mind.** There's no need to worry about forgetting to mail your payment or missing a bill.
- **Automatic Debit is absolutely free.** As a valued CareFirst BlueCross BlueShield customer, you can enjoy the convenience of Automatic Debit at no additional cost.

## How Do I Sign Up?

If you already have coverage with CareFirst BlueCross BlueShield, simply complete the Automatic Debit authorization form and mail it to us. Just indicate which option you prefer - checking account or credit card. Regardless of the option you choose, your monthly charge will automatically take place on the 25th day of each month prior to your coverage month. For example, you will pay your monthly premium on May 25 for coverage in June. Please be sure to include a blank check marked "Void" along with your authorization form so that we can notify your bank. If you are choosing the credit card option, please remember to send us notification when your card expires.

If you're applying for CareFirst BlueCross BlueShield coverage, attach your Automatic Debit authorization form along with a voided check to your application for medical coverage, and return them together to CareFirst.

***Important: It will take four weeks for your Automatic Debit authorization to be processed. Once your application for medical coverage has been processed and approved, you will receive a bill in the mail. When you receive your first bill, you must pay it and send in your payment. It is very important that you pay this bill on time in order to keep your coverage in effect. We will notify you in writing when your monthly Automatic Debit payments will begin. Until that time, please pay any bills you receive.***

## What Else Do I Need To Know?

If there are any changes to your bank or checking account, please let our Customer Service Representatives know right away so that your Automatic Debit option can continue without interruption. If, for whatever reason, you would like to discontinue Automatic Debit, simply call or write us. Your request will take 2 weeks to process. If your account has insufficient funds available to pay the premium amount due, you will receive a double bill the next time along with a letter advising you that if you have one more non-sufficient funds draft, you will be terminated from the program.

To elect the Automatic Debit monthly payment option, just complete and mail the attached authorization form. You will receive an invoice monthly. You do not need to send a check (except for the first month's premium) unless advised in writing.

Please fill out the Automatic Debit Authorization Form and return it today.

# AUTOMATIC DEBIT PLAN AUTHORIZATION FORM

**Yes, I'd like to enroll**

For office use only

(Please Print)

Date \_\_\_\_\_

Policyholder Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_

(Enrolled Members) CareFirst BlueCross BlueShield Group Number \_\_\_\_\_

(Enrolled Members) CareFirst BlueCross BlueShield Identification Number \_\_\_\_\_

## CHOOSE PREFERRED AUTOMATIC DEBIT OPTION

**Checking Account Option**

Bank Name \_\_\_\_\_

Bank Address \_\_\_\_\_

Account Number \_\_\_\_\_

**Authorized Signature** \_\_\_\_\_

Date \_\_\_\_\_

**Credit Card Option**

Type of Credit Card:  VISA®  MasterCard® Exp. Date \_\_\_\_\_  
MM / YY

Account Number \_\_\_\_\_

Name on Credit Card \_\_\_\_\_

**Authorized Signature** \_\_\_\_\_

Date \_\_\_\_\_

*Important: Please attach a blank check marked "Void" showing your pre-printed account number.*

*Failure to provide a copy of your voided check will result in a delay in your Automatic Debit application.*

The completed form must be returned to: Collections Unit/Automatic Debit, CareFirst BlueCross BlueShield, 840 First St. NE, Washington, DC 20065

I (We) hereby authorize CareFirst BlueCross BlueShield to initiate entries to either my/our checking or credit card account indicated above and the Financial Institution named above to credit/debit the same to such account.

CareFirst BlueCross BlueShield will complete the debit transaction only if a voided check containing this information is attached. This authority is to remain in full force and effect until the Financial Institution has received notification from either party of its termination in such time and such manner as to afford the Financial Institution reasonable time to act on it. A customer has the right to stop payment of a debit/credit card entry by notification to CareFirst BlueCross BlueShield and the Financial Institution prior to charging the account. After the account has been charged, a customer has the right to have the amount of any erroneous amount immediately credited to the customer's account by the Financial Institution up to 15 days following issuance of statement or 45 days after posting, whichever occurs first.

In case of errors or questions, write to CareFirst BlueCross BlueShield at the following address:

**Collections Unit/Automatic Debit  
CareFirst BlueCross BlueShield  
840 First Street, NE  
Washington, DC 20065**

By signing below I acknowledge that I have read and understand this authorization.

**Policyholder Signature** \_\_\_\_\_

**Date** \_\_\_\_\_