

# Easy Pay



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

# Easy Pay

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## Five Good Reasons to Sign Up Now

- **EasyPay saves you time and money.**

You no longer have to write checks and pay for postage.

- **EasyPay helps you budget your health insurance**

**premiums.** Now you can pay on a monthly basis like you do with other household expenses.

- **EasyPay provides excellent record keeping.**

Your monthly bank or credit card statement helps keep track of all your premium payments.

- **EasyPay gives you peace of mind.**

There's no need to worry about forgetting to mail your payment or missing a bill if you go out of town.

- **EasyPay is absolutely free.**

As a valued CareFirst BlueCross BlueShield customer, you can enjoy the convenience of EasyPay at no additional cost.

## How Do I Sign Up?

If you already have coverage with CareFirst BlueCross BlueShield, simply complete the EasyPay 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 sixth day of each month. If you are choosing the checking account option, please be sure to include a blank check marked “Void” along with your authorization form so that we can notify your bank.

If you're applying for CareFirst BlueCross BlueShield

coverage, attach your EasyPay authorization form along with a voided check, if necessary, to your application for medical coverage and return them together.

***Important: It will take four to six weeks for your EasyPay 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 that bill, you must 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 EasyPay 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 credit card account, please let our Individual Account Managers know right away so that your EasyPay option can continue without interruption.
- If, for whatever reason, you would like to discontinue EasyPay, simply call or write us.
- If your account has insufficient funds available to pay the premium amount due, we will automatically mail you a bill. This bill will include a \$15 service charge for insufficient funds.
- To elect the EasyPay monthly payment option, just complete and mail the attached authorization form. And remember, when you receive a bill, it is essential that it be paid to keep your coverage active.
- Please fill out the EasyPay Authorization Form and return it today.

## What is EasyPay?

**In a word:** *convenient.*

Convenient, because EasyPay lets you pay your premiums automatically. You 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, EasyPay allows you to pay your premiums on a monthly basis. And EasyPay is available to you at no additional cost.

# EASYPAY AUTHORIZATION FORM

For office use only

**Yes, I'd like to enroll in EasyPay.**

(Please Print)

Name \_\_\_\_\_

Address \_\_\_\_\_

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

CareFirst BlueCross BlueShield Membership Number (if applicable) \_\_\_\_\_

## CHOOSE PREFERRED EASYPAY 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*

I authorize CareFirst BlueCross BlueShield\* (CareFirst) to sign me up for the EasyPay monthly payment option according to the terms of this agreement. I understand that this agreement is for the purpose of paying my CareFirst premium charges only. I understand that an EasyPay transfer will occur on the sixth day of each month. If CareFirst makes any changes to this agreement, CareFirst will notify me in writing at least 21 days in advance. CareFirst will not send me statements detailing EasyPay transfers; these will appear on my bank or credit card statements which I should retain for my records. In case of errors or questions, contact your dedicated customer service representative at 410-581-3414 or 1-800-458-1981 or write to CareFirst at the following address:

**CareFirst/EasyPay**  
**10455 Mill Run Circle, OM2-225**  
**Owings Mills, MD 21117**

If I think an error has been made I will contact CareFirst no later than 60 days after I receive the account statement on which the possible problem or error appears. If I do not notify CareFirst within this 60 day period, I will be responsible for the amount of transfers made during this period, up to a maximum of \$50. CareFirst will investigate my complaint within 10 days of when I contact them. If CareFirst decides that no error exists, I will receive an explanation within 3 business days of the completed investigation. I may ask for copies of any documents used in the investigation. In the case of an error, CareFirst will reimburse me for any amount that is above the limitations of this agreement.

I may stop EasyPay by calling or writing CareFirst by the end of the month before the next scheduled transfer. If CareFirst fails to make any monthly transfer, my insurance will remain in force, except if the transfer was canceled per my

request. If my account has insufficient funds available to pay the premium amount, I will automatically receive a premium bill that includes a \$15 service charge. I authorize CareFirst to disclose any information to my bank or credit card issuer and any fund transfer clearinghouse which is required to process an EasyPay transfer. I understand that CareFirst will not disclose any information supplied on this form to other persons without my authorization. By signing below I acknowledge that I have read and understand this authorization.

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**Policyholder Signature**

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**Date**

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[www.carefirst.com](http://www.carefirst.com)

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