

# IFP automatic payment form

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

## Simplify your life

Automatic payment offers a more convenient, more secure way to pay your plan rate:

- No worries about coverage lapses because you forgot a payment
- Saves time and postage
- Paperless transaction helps the environment
- No added cost for the service

## Our automatic payment options

### Easy\$Pay

A convenient way to pay your monthly dues/premiums automatically. Simply authorize Blue Shield once to withdraw the amount due from your checking or savings account each month.

### Credit card

Pay automatically by credit card and just authorize Blue Shield once to charge your monthly or quarterly payment to your Visa or MasterCard.

## Enroll today

It only takes a few minutes to get started and take the stress out of paying bills:

1. Complete the attached authorization form. Fill out the Easy\$Pay<sup>SM</sup> section for checking or savings account debits, or the Credit Card section for Visa or MasterCard payments.
2. For Easy\$Pay, enclose a blank check or deposit slip marked "void." If you prefer not to attach a voided check or slip, you must provide your bank account number and the routing/transit number (see below).

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

3. Send the completed form back in the enclosed return envelope to:

Blue Shield of California  
P.O. Box 629013  
El Dorado Hills, CA 95762-9989

or fax to (916) 350-8545.

**Please note:** It can take 30 days from the time Blue Shield receives your form to process it, so you should continue to pay by check until we notify you that your automatic payment has been set up.

## Have questions?

Call us at **(800) 431-2809**.

# Automatic Payment Authorization Form

- 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 \_\_\_\_\_

Daytime phone number \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## Easy\$Pay – Checking or savings account debits

Payment date:  1<sup>st</sup> of month  15<sup>th</sup> of month  
HMO and Dental HMO subscribers must use 1st of month

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

Payment date:  
Credit card will be billed on the first of the month

Type of account:  
 Visa  MasterCard

Payment frequency:  
 monthly charge  quarterly charge

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 one to two 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) 431-2809. 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 \_\_\_\_\_

# Automatic Payment Authorization Form: **Keep this section for your records**

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Social Security number \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Print name \_\_\_\_\_

Social Security number \_\_\_\_\_ Date \_\_\_\_\_

# KEEP FOR YOUR RECORDS