Debit Authorization

I (we) hereby authorize Blue Cross and Blue Shield of Massachusetts, Inc., to initiate debit entries to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit the same to such account for premium payments for my (our) Blue Cross and Blue Shield of Massachusetts, Inc., health insurance account. I (we) acknowledge that the origination of such transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution Name | Branch

Address | City/State | Zip

Routing Number | Account Number | Type of Account: Checking ❑ Savings ❑

This authority is to remain in full force and effect until Blue Cross and Blue Shield of Massachusetts, Inc., has received written notification from me (either of us) of its termination in such time and manner as to afford Blue Cross and Blue Shield of Massachusetts, Inc., and FINANCIAL INSTITUTION a reasonable time to act on it.

I (we) understand that if payment for my (our) health insurance premium is refused due to insufficient funds in my (our) account, I (we) have the right to be notified in writing of the deficiency under Massachusetts General Law Chapter 167B, Section 10. I (we) understand that future withdrawals from my (our) account may change based on my (our) membership status and future premium changes.

Signature | Print Individual Name

Print Blue Cross Blue Shield ID Number | Date

Print Blue Cross Blue Shield Group Number—as shown on your bill

Address | Telephone Number

Please Attach Copy of Voided Check or a Preprinted Deposit Ticket to This Form

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