Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Employer Group

Authorization Agreement For Automatic ACH Transactions Medicare Advantage Premium Payments

This form constitutes an agreement of written authorization (hereafter referred to as "agreement") by the company or an authorized representative acting on the company's behalf (hereafter referred to as "company") for automated payment (debit to your account) for recurring ACH transactions to be initiated by **Blue Cross Blue Shield of Michigan**. This written authorization is maintained by Blue Cross for reference in the event of a dispute as evidence of authorization. Both parties agree that this agreement constitutes authorization to debit the company's bank account.

Both parties agree to be bound by National Automated Clearing House Association (NACHA) Operating Rules as they pertain to all ACH transactions initiated by **Blue Cross** that credit or debit the **company** bank account listed below, and acknowledge that the origination of ACH transactions to the listed account must comply with provisions of U.S. law.

Please complete below			
Company name			
Company group number with Blue Cross	Authorization applies to all divisions: ☐ Yes ☐ No If "no," only applies to division(s), list: _____		
Billing address	City	State	ZIP code
Company representative telephone number	Company representative email		

Bank information			
Company name on bank account	Bank name		
Bank account number	Bank routing number	Type of account ☐ Checking ☐ Savings	
Billing address	City	State	ZIP code
This business bank account must be enabled for ACH transactions. Please verify with your bank that ACH debit transactions are permitted on this account. Contact your Service Consultant if you need our ACH company ID to permit ACH debit transactions on this account.			

I authorize Blue Cross Blue Shield of Michigan to initiate ACH debits on the bank account indicated above according to the terms of this agreement.

This authorization is to remain in full force and effect until either party has received written notification from an authorized signatory.

_____ Receiver Authorized Signer

_____ Date

I am an authorized signer, or otherwise have authority to act, on the account identified in this statement.

_____ Print Name

_____ Title

Please mail this form to:
Blue Cross Blue Shield of Michigan
P.O. Box 44256
Detroit, MI 48244-0256

Or Fax to: 1-866-533-5810