



**AUTHORIZATION AGREEMENT FOR
AUTOMATIC WITHDRAWAL**

From Checking or Savings Account

Submit this form only if you have selected Option 2 in Section III on the enrollment form and wish to have premium payments automatically deducted from your checking or savings account. Submit one form for each applicant.

| | | | |
|----------------|---------------------|-------|----------|
| Applicant Name | | | |
| Street Address | City | State | Zip Code |
| Bank Name | Bank Account Number | | |

If you are a current member, provide your Member ID number.

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|---|
| Applicant Medicare Plus Blue Member Number - (located on your ID card), if available |
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Please deduct my monthly **Medicare Plus Blue** premium from **(check one of the following)**

- Checking Account (voided check must be attached)
- Savings Account (voided deposit slip must be attached)

I hereby authorize **Medicare Plus Blue** to withdraw from checking/savings account amounts necessary to pay the premium I owe. This authority will remain in effect until I notify **Medicare Plus Blue** in writing to cancel, with enough time to allow the bank a reasonable opportunity to act on the cancellation.

Please attach either a voided check for checking withdrawal or deposit slip for a savings withdrawal.

You may receive a premium bill during the time your application is being processed so please pay such bills *until you are advised that your application has been approved.*

_____ Date
 Applicant/Authorized Signature
 Relationship to Applicant _____

Please allow 3-4 weeks for processing your application. You may receive a premium bill during the time your application is being processed so please pay the bill. Future monthly premiums will be automatically withdrawn from your specified account on the fifth day of every month.

Please attach either a voided check for checking withdrawal or deposit slip for savings

Please note: We cannot process your request without a voided check or deposit slip.

If any information is missing, we will return this form to you for completion. For questions regarding this form please call: 1-800-485-4415, 7 days a week, from 8 a.m. to 8 p.m. EST. TTY users may call 1-800-481-8704.

Please mail this form to: Medicare Plus Blue or Fax to: 248-448-4041
 PO Box 440
 Southfield, MI 48037

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