Blue Cross® Medicare Supplement Authorization Agreement for Automatic Premium Payments

Automatic premium payments offers the convenience of paying your Blue Cross Medicare Supplement premium bill automatically from your bank account each month. No need to write checks, mail payments or worry about late payments. To participate, simply fill out and mail in this form. If payment will automatically be deducted from your checking account, please include a blank, voided check from your designated account for verification and allow three to four weeks for processing. If payment will automatically be deducted from your savings account, documentation is not required. Continue to mail your payment until your bill reflects automatic payments are being made. To ensure that you receive email notifications and reminders when your bill is ready, and to expedite processing time, sign up online at **https://www.bcbsm.com/medicare/help/forms-documents/payments.html**.

If checking account is used, please mail or fax this form and your voided check to:

Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit, MI 48244-0407

Or

Fax to 1-866-392-7528

Complete the requested information below. *(Please print or type.)*

Last name _____ First name _____ Middle initial _____

Address _____

City _____ State _____ ZIP code _____

Blue Cross account number (16-digit number on your bill) _____ Daytime phone number _____ Email _____

Please include a blank, voided check from your designated account if checking account is selected. If savings account is selected, documentation is not required.

Account holder name _____ Check one: ❑ Checking account ❑ Savings account

Name of financial institution _____ Bank account number _____ ABA/routing number (9 digits) _____

This form cannot be processed without your signature.

I authorize Blue Cross Blue Shield of Michigan to deduct my payments from the checking or savings account listed above. I understand that I control my payments, and if at any time I decide to discontinue this payment method, I will notify Blue Cross. I also understand that all information provided will remain confidential.

Signature _____ Date _____