



Take these three simple steps to hassle-free monthly premium payments

- Complete and sign this authorization agreement.
• Verify with your financial institution that they can accept automated electronic withdrawals.
• Return this authorization and a blank check marked VOID for the account from which funds are to be withdrawn to: Blue MedicareRx, PO Box 2190, Chester, VA 23831.
Your payments will be deducted approximately the 4th of each month.

AGREEMENT

I, as account holder, hereby authorize HCSC Insurance Services Company (HISC) to initiate withdrawals on a monthly basis from my account at the financial institution named in this authorization for payment of monthly Blue MedicareRx insurance premium due for the named policyholder; and, I authorize the financial institution to charge such withdrawals to my account.

A draft shall be drawn each month on or about the premium due date of the policy/contract. As the account holder, by signing below, I also certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction, that the company is not paying any portion of the premium for this subscriber, either directly, or through reimbursement, and that the employer/company is not deducting any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code. I understand that both the financial institution and HISC reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program (except on individual temporary contracts) at any time with at least 10 days advance notice to HISC by telephone prior to a scheduled withdrawal date.

I am authorizing my insurance premium due for this Blue MedicareRx coverage, be paid as described in this agreement and agree that if any withdrawal is dishonored, the premium payment for such withdrawal will be considered in default. I also authorize the disclosure of my policy identification/group numbers and any other necessary personal information on the financial institution's statements to identify to the account holder named for whom withdrawals are being made.

PLEASE COMPLETE THE FOLLOWING • Print or type information

Yes, I elect to have my insurance premium paid monthly through the Automatic Premium Payment Program.

Member Name
Group Number Member ID
Daytime Phone Number
Address

Account Holder Name(s)
Daytime Phone Number
Home Address
Full Name of Financial Institution
Account Number
As shown on account records
As accepted by financial institution

I have read and accept the above agreement.

Signature
Account Holder Signature(s)
(If different from the Member)

SM Service Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

[®] Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

Blue Cross and Blue Shield of Illinois refers to HCSC Insurance Services Company, which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Part D products under HCSC Insurance Services Company's contract S5715 with the Centers for Medicare and Medicaid Services.