

# Monthly Automatic Withdrawal (Pay-O-Matic) is Convenient!

You won't need to write a single check or buy a stamp. And there's no extra cost to you! Once a month, on your billing date, we'll deduct your payment directly from your bank or credit union account.

Please attach a check marked void here with tape.

**DO NOT STAPLE**

## Getting started

- 1 **Complete the Monthly Automatic Withdrawal (Pay-O-Matic) authorization form.**
- 2 **Attach a check marked void if using a checking account. Attach a savings deposit slip if using a savings account.**
- 3 **Mail this form with your voided check attached to the address shown.**

You can choose to stop monthly automatic withdrawals and switch back to quarterly paper billing any time. Just let us know in writing **at least 15 days before your next withdrawal date** to allow for timely deactivation.

## Monthly Automatic Withdrawal (Pay-O-Matic) Authorization Form

I request and authorize Blue Cross and Blue Shield of Minnesota (Blue Cross) and Blue Plus to deduct my payment from my  checking or  savings account shown below.

Name on bank account \_\_\_\_\_

Bank name \_\_\_\_\_

Bank account number (attach a void check above) \_\_\_\_\_

Branch office address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If you are a new customer and you are sending this authorization along with an application for coverage, please enclose a check for one month's payment. If you are an existing member, do not send money.

Blue Cross or Blue Plus has the right to end this authorization by sending written notice to my current address as shown in Blue Cross or Blue Plus records.

I understand that this authorization may be stopped by notifying Blue Cross or Blue Plus **at least 15 days before my account is to be charged for the next payment**. I also understand that only the amount of the payment deducted by Blue Cross or Blue Plus will be repaid to me by check after notification in accordance with these instructions.

Name of applicant/member (please print) \_\_\_\_\_

Applicant/member's social security number or Blue Cross id#: \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of account holder

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of account holder (if joint account)

Coverage is provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

MAIL TO: Blue Cross and Blue Shield of Minnesota, P.O. Box 64500, St. Paul, MN 55164-0500