

Tired of Paying Your Health Insurance Bill?

—Then Let Us Do it for You!



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

Enroll in Arkansas Blue Cross and Blue Shield's Pre-authorized Monthly Bank Draft Program!

- *No checks to write, no bills to keep, no stamps to buy.*
- *Bills are paid even when you're away from home.*
- *Never risk a lapse in coverage.*
- *This service is provided at no cost to you.*

Important Note: Your first monthly premium cannot be paid by bank draft. You must pay at least one month's premium by check. Please do **not** pay your premium now. You will be billed later.

Here's How to Sign Up ...

1. Complete the information requested below.
2. Since we need information on your check, please attach a blank check from the account from which you want payment taken. Be sure to write "void" on the check before mailing it.
3. Complete the authorization form below and return to Arkansas Blue Cross and Blue Shield, P.O. Box 2181, Little Rock, AR 72203-2181, along with voided check and application.
4. If payment is to be withdrawn from an account other than yours, the person making your payments should follow the above directions.

After we receive your Authorization Form and voided check, we will change your payment method to the Bank Draft Program. You will be notified by letter of the effective date of your first draft. Please allow approximately 30 days to establish the pre-authorized draft. If you receive a bill during this time, pay it as you normally would.

IMPORTANT: PLEASE READ AND COMPLETE THIS SECTION.

I authorize Arkansas Blue Cross and Blue Shield, a Mutual Insurance Company, and the BANK* indicated below, to debit my Arkansas Blue Cross and Blue Shield premium from my checking account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK'S termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my Arkansas Blue Cross and Blue Shield coverage, UNLESS Arkansas Blue Cross and Blue Shield has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

Bank Name _____

Location _____ City _____ Zip _____ Account No. _____

Insured's Name _____

Insured's Address _____ Street _____ Apt. No. _____
City _____ State _____ Zip _____

Signature _____ Date _____
Signature of Account Holder

*BANK also applies to Savings and Loan.

REMEMBER TO ENCLOSE A VOIDED CHECK WITH REQUEST.

FOR OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

I.D. NO.	GROUP NO.	EFFECTIVE DATE	AMOUNT	STATUS