



**BLUE CROSS OF CALIFORNIA**  
 P.O. Box 9063  
 Oxnard, CA 93031-9063

**OPTIONAL**  
**Monthly Checking Account Deduction Authorization**  
**for Supplemental Coverage for Seniors**

The Blue Cross of California automatic premium payment program allows you to have your monthly Blue Cross of California premium deducted from your checking account. To participate in this program, please fill out and sign this form following the instructions on the right. This form authorizes us to automatically withdraw your premium from your personal checking account on the sixth day of each month. Your blank check marked "VOID" must accompany this form when returned. Please do not submit your deposit slip.

SUBSCRIBER'S NAME	
CERTIFICATE NUMBER	GROUP NUMBER
BANK NAME	
BLUE CROSS USE ONLY	

**AUTHORIZATION TO HONOR CHECK DRAWN BY AND PAYABLE TO BLUE CROSS OF CALIFORNIA**

CERTIFICATE NUMBER	GROUP NUMBER
BANK ACCOUNT IN NAME OF <b>X</b>	<b>X</b>
ACCOUNT NUMBER	DATE

As a convenience to me, I request and authorize you to pay and charge to the above account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing or verbally, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check. I further agree that if any such check is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability.

BANK NAME (PLEASE PRINT)
BANK ADDRESS
CITY, STATE AND ZIP

**X**

SIGNATURE OF DEPOSITOR	DATE
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**X**

SIGNATURE OF DEPOSITOR	DATE
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**INSTRUCTIONS**

Be sure all areas of the form are completed and the authorization is signed.

- Enclose your blank check marked "VOID".
- Type or print clearly in ink:

Group Number will be entered by Blue Cross if not known.



**CHECK LIST**

- A sample of your check marked "VOID" is enclosed.
- Monthly Checking Account Deduction Authorization is completed, signed, and enclosed.
- Your check is enclosed.

Account Holder(s) Name(s). (Print clearly.)

Account Number (may be left blank if not known) and date.

**YOU MAY NEED TO INCLUDE A PAYMENT WITH THIS FORM.**

For **initial** enrollment, please submit first one month's premium. Your automatic premium payment will start in 30 days.

If you already have Blue Cross coverage and have **not** paid one month's premium advance, please submit one month's premium now. Your automatic premium payment will start at your next paid-to date.

If you already have Blue Cross coverage, and **have** paid one month's premium in advance, your automatic premium payment will start at your next paid-to date.

Each month when you receive your bank statement, your Blue Cross automatic premium payment will be reflected.

Signature as shown on bank records. If joint account, both account holders' signatures are required.

**TO: THE BANK NAMED ON THE REVERSE SIDE**

So that you may comply with your depositor's request, Blue Cross of California agrees that:

1. We will hold you harmless from liability to any person having an account with you which arises out of payment by you of any check drawn by Blue Cross of California on the account of such person. You will not be liable, even though you dishonor this check, whether with or without cause or intentionally or inadvertently, even though that action results in forfeiture of Blue Cross membership for your depositor.
2. We will refund to you any amount paid erroneously by you on any such check, if claim for the amount of such payment is made by you within twelve months from the date of the check on which the erroneous payment was made.

**AUTHORIZATION**

**Protected Health Information (PHI) to be Used and/or Disclosed:** All information relating to my contract with Blue Cross of California.

**Entities or Persons Authorized to Use or Disclose:** Blue Cross of California or affiliate ( Blue Cross) its agents, employees, designees or representatives.

**Entities or Persons Authorized to Receive:** Persons paying membership premium for my Blue Cross coverage via automatic checking account deduction.

Spouse (name shown on page one of this document) AND/OR

Print Names: \_\_\_\_\_

**Purpose of this Authorization:**  At request of individual. By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to the individuals named above. This authorization is a condition of Blue Cross deduction of premium from a checking account other than your own. This authorization is also a condition of the persons (listed above) to receive any and all Protected Health Information and to act on my behalf.

**No Conditions:** This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

**Effect of Declining:** If you decide not to sign this authorization, we will bill you on a bimonthly basis to your residence address on file. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

**Expiration:** This authorization will expire upon termination of any Blue Cross coverage that may be in effect.

**Right to Revoke:** I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written or verbal notice of revocation. I understand that I may revoke this authorization at any time by giving written or verbal notice of my revocation to:

**Blue Cross of California**  
**PO. Box 9063, Oxnard, CA 93031-9063**  
**Telephone 800-333-3883, Fax 805-375-0361**

I have had full opportunity to read and consider this authorization, and I understand that, by signing this authorization, I am authorizing the use and/or disclosure of my Protected Health Information, as described in this authorization.

\_\_\_\_\_ **X** \_\_\_\_\_

**Print Name** **Signature** **Date**

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

\_\_\_\_\_

**Personal Representative: Print Name** **Relationship to Individual**

\_\_\_\_\_

**X** \_\_\_\_\_

**Signature** **Date**

A photocopy of this authorization is as valid as the original. YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.