



**Group Authorization Agreement for Automatic Payments**

|             |  |                       |  |
|-------------|--|-----------------------|--|
| Group name: |  | Group decision maker: |  |
|-------------|--|-----------------------|--|

|               |              |                 |  |
|---------------|--------------|-----------------|--|
| BCN group ID: | Subgroup ID: | Street address: |  |
|---------------|--------------|-----------------|--|

|       |        |           |                   |
|-------|--------|-----------|-------------------|
| City: | State: | Zip code: | Telephone number: |
|-------|--------|-----------|-------------------|

**Authorization for automatic payments**

I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my group's checking/savings account amounts necessary to pay the premium owed by my group under my group's BCN contract. This authority will remain in effect until I, or another group representative, notifies you, or the bank listed below, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation.

|            |         |
|------------|---------|
| Bank name: | Branch: |
|------------|---------|

|       |        |           |
|-------|--------|-----------|
| City: | State: | Zip code: |
|-------|--------|-----------|

Please deduct my monthly BCN premium from (check one):

- Checking account (Please include a voided check when you return this form.)
- Savings account (Please include a voided deposit slip when you return this form.)

If you bank online, please write in your checking or savings account number and bank routing number.

Account number \_\_\_\_\_

Bank routing number \_\_\_\_\_

|                                    |       |
|------------------------------------|-------|
| Signature of group decision maker: | Date: |
|------------------------------------|-------|

Requests received by the 5th of the month will take effect the following month. Withdrawals will occur each month on the date your premium payment is due. We will send you written notification of the date your automatic payments begin. Please fax, email or mail the completed form to:

Fax: 1-866-615-6793  
Email: [bcnaccountsreceivable@bcbsm.com](mailto:bcnaccountsreceivable@bcbsm.com)

Mail: Blue Care Network  
Collections - Mail Code C415  
P.O. Box 5043  
Southfield, MI 48086-5043

**Blue Care Network use only**

|            |               |                 |
|------------|---------------|-----------------|
| Processor: | Process date: | Effective date: |
|------------|---------------|-----------------|