



Authorization Agreement for Automatic Payments

Subscriber name:		Subscriber address:	
City:	State:	Zip code:	Subscriber telephone number:

Authorization for automatic payments

I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my checking/savings account amounts necessary to pay the premium owed by me under my BCN contract. This authority will remain in effect until I notify 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:	Date:
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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.

Blue Care Network use only

Member's contract number:	Process date:	Effective date:
Processor:		

Blue Care Network
IAA/Billing Department - Mail Code C415
20500 Civic Center Drive
Southfield, MI 48076-4115

White ply – Mail to BCN.

Yellow ply – Keep for your records.