

# Sure Pay Authorization Form

## Save the hassle of writing us a check.

With Sure Pay, there's no bill to keep track of. No check to write. And nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account.

Just complete and sign this authorization form. Mail or fax it to us, and we'll handle all the details with your bank.

Please note that your first monthly premium may be deducted after your normal payment due date.

If the first deduction is delayed, it may be for more than one monthly premium.

Complete and sign form, then mail or fax to: Enrollment Services, Blue Cross Blue Shield of Arizona  
P.O. Box 13466, Phoenix, AZ 85002-3466 • Fax (602) 864-4041

## Pay your premiums the convenient way with Sure Pay!

PERSON TO BE BILLED				
LAST NAME		FIRST	INITIAL	DAYTIME PHONE (   )
ADDRESS		CITY		STATE      ZIP CODE
PLEASE DEBIT MY:		ROUTING TRANSIT NUMBER	ACCOUNT NUMBER	
<input type="checkbox"/> CHECKING ACCOUNT <input type="checkbox"/> SAVINGS ACCOUNT				

IF APPLICANT IS DIFFERENT FROM PERSON TO BE BILLED, PROVIDE INFORMATION ON APPLICANT BELOW:
NAME
BLUE CROSS BLUE SHIELD OF ARIZONA ID NO.

JOHN DOE 123 Any Lane Anywhere, USA 12345	Date _____	123
Pay to the ORDER OF _____	\$ _____	
MEMO _____		
:0101010101:      .0101010101	123	
Routing Number	Account Number	Check Number

## Important: Remember to sign the authorization below.

I authorize Blue Cross Blue Shield of Arizona (BCBSAZ) to start an automatic periodic charge to my checking or savings account as noted on this form. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.

I want this charge to continue automatically until I write BCBSAZ telling them to discontinue my Sure Pay service. I agree to allow a reasonable time for discontinuance of Sure Pay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Sure Pay withdrawals.

I understand BCBSAZ and my financial institution have the right to discontinue this service if either elects to do so.

I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month or twice the amount the following month. My BCBSAZ coverage will be terminated if there are insufficient funds in two consecutive drafts.

I have read and agree to abide by the Sure Pay conditions as outlined on this authorization form.

\_\_\_\_\_  
Authorized signature on account

\_\_\_\_\_  
Date