Anthem BlueCross BlueShield

Application for Medicare Supplement and Anthem Extras – Connecticut

Anthem Blue Cross and Blue Shield
108 Leigus Road • Wallingford, CT 06492

Instructions

For assistance, call us at **1-800-238-1143**. To be considered for coverage, you must live in **Connecticut**. Please answer all questions fully. Submit application within 90-days of signature date.

Important Statements

Please read the six statements below.

1. You do not need more than one Medicare Supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If you are enrolled in the Qualified Medicare Beneficiary (QMB) Program you cannot purchase a Medicare Supplement plan as it duplicates coverage.

4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid, for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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108 Leigus Road • Wallingford, CT 06492

☐ New Enrollment
☐ Change to Existing Anthem Medicare Supplement Plan

Section A: Applicant Information (Please print and use black ink only.)

Last Name	First Name	MI	Sex ☐ M ☐ F
Home Street Address (Physical Address, not a P.O. Box)			Apt #
City	County	State	Zip Code
Mailing Address (if different than above)	City	State	Zip Code
Billing Address (if different than above)	City	State	Zip Code

Social Security Number	Date of Birth (MM/DD/YYYY)	Age	Home Phone Number
- -	/ /		( )

Language Preference (Optional): ☐ Decline

Written Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Spoken Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Please complete the information below using your Medicare card (include all letters and numbers).

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Medical (Part B) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Section B: Plan Selection

I would like to apply for Medicare Supplement Plan (check only one box):

☐ Plan A* ☐ Plan F ☐ Plan G ☐ Plan N

*If you are under age 65, eligible for Medicare due to disability, these Plan(s) are available to you.

Policy Effective Date: _____ (MM) / _____ (DD) / _____ (YYYY)

Coverage is effective as of the 1st of the month following approval of your completed application. To ensure continuation of coverage, you can request an initial effective date other than the 1st of the month. The effective date must be within 180-days of application signature. After the initial effective date, your policy will move to a 1st of the month anniversary date.

Have you purchased a stand-alone Prescription Drug Plan (PDP)? ..... ☐ **Yes** ☐ **No**

a. If yes, with what company? _____ PDP Effective Date: ____ / ____ / _____

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section C: How Do You Wish to Pay Your Premium? (SEND NO MONEY NOW!)

Automated Bank Draft*

- ☐ Monthly – save $2 per month
- ☐ Quarterly – save .25% per quarter
- ☐ Annual – save 2.85% per year

Paper Bill (Send to **Billing Address** in Section A)

- ☐ Monthly
- ☐ Quarterly – save .25% per quarter
- ☐ Annual – save 2.85% per year

* Please complete the **Premium Payment Form**. Drafts are made to your account on the 6th day of the month.

Household Discount Determination – Save 5%:

When more than one member in the same household enrolls in a Medicare Supplement plan with us, they may qualify for our Household Discount. If you believe you qualify for the discount please provide the following information in order for us to verify eligibility. If eligible, the discount applies to both parties.

Last Name _____ First Name _____ MI _____

Medicare Claim Number: _____

Anthem Member ID Number: _____

Section D: Other Coverage Information

RESPONSES TO THE FOLLOWING QUESTIONS ARE REQUIRED FOR YOUR PROTECTION. To the best of your knowledge, please answer all questions by marking "Yes" or "No" with an "X". If you recently lost, are losing or replacing other health insurance coverage and received a notice stating you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice with your Application.**

1. a. Did you turn age 65 in the last 6 months? ☐ **Yes** ☐ **No**

b. Did you enroll in Medicare Part B in the last 6 months? ☐ **Yes** ☐ **No**

If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program? ☐ **Yes** ☐ **No**
Note to Applicant: If you are participating in a "Spend-Down Program" and have not met your Share of Cost, please answer "No" to this question.

If yes,

a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ **Yes** ☐ **No**

b. Do you receive any benefits from Medicaid **OTHER THAN** payments toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

Complete this section if you had coverage under a Medicare Supplement (Medigap) or Medicare Advantage (HMO, PPO, etc.) plan within the last 63 days.

3. a. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, like a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. (If you know your upcoming coverage end date, then enter that date).

START _____ / _____ / _____ END _____ / _____ / _____

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section D: Other Coverage Information *(continued)*

b. If ending, indicate reason why your coverage is ending: _____

c. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ **Yes** ☐ **No**

d. Was this your first time in this type of Medicare plan? ☐ **Yes** ☐ **No**

e. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ **Yes** ☐ **No**

4. a. Do you currently have a Medicare Supplement policy in force? ☐ **Yes** ☐ **No**

b. If yes, Company: _____ Plan: _____

Do you intend to replace your current Medicare Supplement policy with this policy? ☐ **Yes** ☐ **No**

c. If yes, what is your expected "END" Date? END _____ / _____ / _____

5. Have you had coverage under any other health insurance within the past 63 days? ☐ **Yes** ☐ **No**
(for example, an employer, union or individual plan)

a. If yes, Company: _____ Policy Type: _____

b. If yes, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. If you know your coverage end date, then enter that date.)

START _____ / _____ / _____ END _____ / _____ / _____

Policy Number: _____ Customer Service Phone Number: _____

c. If ending, indicate reason why your coverage is ending: _____

Section E: Anthem Extras Packages (Additional Premiums Apply)

To be eligible for this coverage, you must be at least 65 years of age or older when the policy becomes effective.

These optional benefits are available to you for an **additional premium**.

If you currently have medical or dental coverage through Anthem Blue Cross and Blue Shield, please provide your

Identification Number: _____

If you are still covered under this plan, leave "END" blank. START ____ / ____ / ____ END ____ / ____ / ____

If you are a current Anthem Blue Cross and Blue Shield member, what insurance do you have with us?

☐ Individual Dental
☐ Group Dental

The **effective date** will be the same as the effective date on **page 2** of the Medicare Supplement application.

Anthem Extras Offerings:

☐ Standard Package ☐ Premium Plus Package
☐ Premium Package ☐ Premium Plus Dental (**only**)

Billing/Payment options:

Select One: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Select One: ☐ Paper Statement (mailed to **Billing Address** in Section A)

☐ Automatic Bank Draft (Premium deducted same day as your effective date – Anthem Extras Premium Payment Form required)

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section F: Authorizations and Agreements

I, the applicant or my authorized representative:

1. affirm all answers provided on this application are true, complete and correct **(including information relating to Medicare coverage) and that any false statement or misrepresentation on the Application may result in loss of coverage under the policy** and that it is my/our responsibility for accurately completing this Application;

2. understand it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits;

3. understand if coverage is rescinded for fraud or intentionally misleading statements Anthem Blue Cross and Blue Shield will reimburse any premium paid less any claims paid and I/we will be responsible for claims paid exceeding any premium paid;

4. understand that I/we are responsible for notifying Anthem Blue Cross and Blue Shield in writing of any new/changes to information on this application before coverage becomes effective that makes my application incorrect or incomplete;

5. understand that there is a six-month benefit waiting period for any condition that I received medical treatment or advice in the six months prior to the effective date of this Medicare Supplement policy. Prior health insurance coverage will be counted toward this 6-month benefit waiting period, if there is not a break in health insurance coverage greater than 63 days;

6. understand the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy, premium or terms of any Company coverage and that he/she may be compensated based on my enrollment;

7. understand upon acceptance that my Application will become part of the agreement between the Company and myself;

8. authorize Anthem Blue Cross and Blue Shield to use and disclose my personal information when necessary for the operation of my health or other related activities and that Anthem Blue Cross and Blue Shield will comply with the HIPAA Privacy Rules and any disclosures will be done in accordance with applicable laws;

9. understand that my payment by check (or resubmission due to insufficient funds) may be converted to an electronic Automated Clearinghouse (ACH) debit transaction, that my check will not be returned to me and that this process will not enroll me in any automatic debit process;

10. acknowledge responsibility for any overdraft fees permitted by state law;

11. acknowledge receipt of:

    - Choosing a Medigap Policy: *A Guide to Health Insurance for People with Medicare,*
    - the *Outline of Coverage,* and
    - a copy of this Application

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section G: Policy Issuance

IMPORTANT: This Application cannot be processed until the applicant signs below. By signing below, the applicant certifies that he/she understands and agrees to the Authorizations and Agreements outlined in the Application.

Please do not cancel your present coverage, if any, until you receive documentation from Anthem Blue Cross and Blue Shield, such as an ID card or written notification, showing that your Application has been approved.

To ensure timely processing, verify the following:

1. Complete, sign and date all sections as indicated by signature boxes.
2. If you want the convenience of automatic bank draft for payment purposes, be sure to complete the **Premium Payment Form.**
3. If replacing a Medicare Supplement or Medicare Advantage policy, the **Replacement Notice** is signed and dated by both you and your insurance agent (if applicable) and returned with your Application.

Please mail the entire Application (including any additional forms) to the address below:

Anthem Blue Cross and Blue Shield
P.O. Box 659816
San Antonio, TX 78265-9116

OR, fax to: 1-844-236-7967

Signature of Applicant, or Authorized Representative (if applicable)* PLEASE MAKE A COPY FOR YOUR RECORDS. X	Date

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to Application (such as a Power of Attorney).

— SEND NO MONEY NOW —
PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED.

Section H: Agent/Broker Information Only:

If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

IMPORTANT: Before this form can be processed, the agent/broker's current health and life license must be on file. In addition, the agent/broker must be appointed with us.

Agent/Broker No.: _____

Agency No.: _____

(Any commission will be processed using these identification numbers.)

Agent/Broker's Printed Name: _____

Phone No.: (_____) _____

Fax No.: (_____) _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Section H: Agent/Broker Information Only: *(continued)* If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

Attestation – Please check one of the following:

☐ I did not assist this applicant in completing and/or submitting this Application by phone, e-mail or in person.

☐ I certify that the applicant has read, or I have read to the applicant, the completed Application. To the best of my knowledge, the information on this Application is complete and accurate. I explained to the applicant, in easy-to understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I certify that the applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

Agent: If you state any material fact that you know to be false, you are subject to a civil penalty.

List all health insurance policies sold to the applicant in the past five (5) years, either in force or not:

Company Name	Policy/ Certificate Number	Type of Coverage	Policy Effective Date	Policy Term Date (if applicable)

I have read and understand the Application. I certify that the applicant has both Medicare Parts A and B, I have given the applicant the *Guide to Health Insurance for People with Medicare*, the *Outline of Coverage* for the policy applied for and a copy of this application. I have requested and received documentation that indicates that the policy applied for will not duplicate any health insurance coverage. I have verified the information in the Replacement Notice section.

Agent/Broker's Signature: X _____ **Date of Signature:** _____

Notice to Applicant Regarding Replacement of
Medicare Supplement Insurance or Medicare Advantage

Anthem Blue Cross and Blue Shield

108 Leigus Road • Wallingford, CT 06492

Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  _____

- ☐ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical and health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

X _____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

X _____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales

Notice to Applicant Regarding Replacement of
Medicare Supplement Insurance or Medicare Advantage

Anthem Blue Cross and Blue Shield

108 Leigus Road • Wallingford, CT 06492

Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  _____

- ☐ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical and health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

X _____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

X _____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales

Anthem Blue Cross and Blue Shield
P.O. Box 659816
San Antonio, TX 78265-9116
Fax: 1-844-236-7967

Anthem BlueCross BlueShield

Premium Payment Form for Medicare Supplement and Anthem Extras Packages

With Automatic Bank Draft, Anthem Health Plans (Anthem)
will automatically draft your premium directly from your checking account.

Full Name (please print)		Phone	
Home Street Address (Physical Address, not a P.O. Box)		Apt #	
City	County	State	ZIP Code
Mailing Address (if different than above)	City	State	ZIP Code
Billing Address (if different than above)	City	State	ZIP Code

Medicare Supplement

Simplify Your Life! It saves you valuable time and money.

By signing up for monthly Automatic Bank Draft, we will reduce your monthly premium by $2.

(Available on Medicare Supplement policies with an effective date on or after June 1, 2010.)

☐ EXISTING MEMBER (Changing Medicare Supplement Payment Option to Automatic Bank Draft)

Medicare Supplement Identification Number (as shown on Medicare Supplement ID card): _____

(Allow 6-8 weeks to process your authorization. Continue to pay as billed until receiving a confirmation letter that we have set up Automatic Bank Draft for your premiums.) Please return this form to: Anthem Blue Cross and Blue Shield, P.O. Box 659816, San Antonio, TX 78265-9116.

Deduct Premium (select one): ☐ Monthly* ☐ Quarterly* ☐ Annually*

(*Applicable discounts for Automatic Bank Draft are not guaranteed and are subject to change.)

☐ NEW APPLICANT (Initial Submission of a Medicare Supplement Application)

I understand that the premium for the coverage I have selected is $_____.*

If your application is accepted and the amount you indicated is less or more than the actual premium amount, the difference will be reflected as a debit or credit on the first bill you receive. If the amount received is not within our payment guideline threshold, we will notify you. ***To ensure proper payment setup, this form MUST be returned with your Application.*

Premiums are subject to change on or after the policy renewal date in accordance with the terms of the Policy. Your Premium Billing Preference selection does not guarantee your Premium for any specific time period. The policy renewal date is defined as generally January 1, subject to state approval. Please refer to your *Outline of Coverage* for additional information regarding changes in Premiums.

Anthem Extras Packages

☐ EXISTING MEMBER (Changing Anthem Extras Packages Payment Option to Automatic Bank Draft.)

Anthem Extras Identification Number (as shown on Anthem Extras ID card): _____

Billing number (starting with SR): _____

(Allow 6-8 weeks to process your authorization. Continue to pay as billed until receiving a confirmation letter that we have set up Automatic Bank Draft for your premiums.)

Deduct Premium (select one): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ NEW APPLICANT (Initial Submission of a Anthem Extras Packages Application)

I understand that the premium for the coverage I have selected is $_____.*

If your application is accepted and the amount you indicated is less or more than the actual premium amount, the difference will be reflected as a debit or credit on the first bill you receive. If the amount received is not within our payment guideline threshold, we will notify you.* ***To ensure proper payment setup, this form MUST be returned with your Application.*

Banking Information For Any Medicare Supplement and Anthem Extras Packages Selected Above

BANK INFORMATION (For Existing Member and New Applicant)

Deduct Premium From: ☐ Checking Account **Start Date:** _____/____/_____

Is this a business account: ☐ Yes ☐ No

Account Holder Name(s):

Name of Financial Institution:

Bank Routing/Transit Number (9 digits)	Bank Account Number
_ _ _ _ _ _ _ _ _	_____

(continued)

Automatic Bank Draft Payment: I hereby authorize the Company to make withdrawals from the account indicated above for the then-current premium(s), and the designated financial institution named above to debit the same account.

I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Anthem Blue Cross and Blue Shield when set up, I authorize my bank to draft both the past due premium along with current premium(s) to ensure my coverage stays in effect. If I close this account, it is my responsibility to provide notification at least two weeks in advance of closing the account. I acknowledge responsibility for any overdraft fees permitted by state law.

I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception**: In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. I understand Anthem Blue Cross and Blue Shield and my financial institution have the right to discontinue the bank draft if they wish to do so. I understand my monthly bank statement will reflect the premium transaction and that I will not receive a bill.

Return this authorization as indicated above. **No service fees apply when paying by Automatic Bank Draft.**

Account Holder's Signature (as it appears on your bank account)	**Date**

Refer to the image below to identify where to locate the Routing Number and Bank Account Number. Do not include the check number as part of the Routing or Account Number.