



ND

An independent licensee of the Blue Cross & Blue Shield Association

Automatic Payment Withdrawal

Name: _____ Daytime Telephone Number: _____

Address: _____

Benefit Plan Number: _____ Requested Effective Date: _____

Name of Financial Institution: _____

Address of Financial Institution: _____

ABA (bank routing) Number: _____ Account Number: _____ checking savings

I hereby authorize my Financial Institution to deduct the current premium from my checking or savings account and remit the same to BCBSND. This authorization is to continue in effect until revoked by me in writing. I understand a 30-day notice is needed when canceling an automatic withdrawal authorization. BCBSND is not responsible for overdrafts and fees due to insufficient funds in my account.

Date: _____ Signature: _____

Please attach a voided check and return to Blue Cross Blue Shield of North Dakota, 4510 13th Ave S, Fargo, ND 58121.