Authorization Agreement for Automatic Payment Withdrawal

BlueCross BlueShield Kansas

Submit this form if you wish to have premium payments automatically deducted from your checking or savings account. Submit one form for each applicant.

Section 1 – Applicant Information

Account Holder Name

Street Address

City

State ZIP Code +4

Bank Name

Bank Account Number

Bank Routing Number

Medicare ID Number (if you are a current member)

Section 2 – Payment Option

Please deduct my monthly premium from: (select one)

☐ Checking Account (voided check must be attached)

☐ Savings Account (deposit slip must be attached)

Withdrawals will be made from your specified account on the first day of each month.

I hereby authorized Blue Cross and Blue Shield of Kansas to withdraw payments from my checking or savings account in the amount necessary to pay the premium I owe. This authority will remain in effect until I notify Blue Cross and Blue Shield of Kansas in writing to cancel. Please allow 60 days to give the bank a reasonable opportunity to act on the cancellation.

Please attach either a voided check (for checking withdrawal) or a deposit slip (for savings withdrawal).

NOTE: You may receive a premium bill during the time your application is being processed. If so, please pay the bill.

Your signature required

Applicant (Signature of authorized representative if other than applicant)

Date Signed

Please mail this completed form to:

Blue Cross and Blue Shield of Kansas
P.O. Box 211355
Eagan, MN 55121

or fax to: 800-426-6535

Please allow up to 60 days to process your request.

If you have questions, please call Blue Cross and Blue Shield of Kansas at 800-222-7645. TTY users should call 711.
We are open 8 a.m. to 8 p.m., seven days a week from Oct. 1 through Mar. 31; or 8 a.m. to 8 p.m., Monday through Friday from Apr. 1 through Sept. 30.