



**Payment Method** (Premium payment required. Please choose from A or B.)

**A. Please choose from the following options for initial payment and future payments. If you choose one of these options, you are not required to send in a paper check for initial payment:**

Monthly Credit/Debit Card (complete Section C)                       Monthly Checking Account Automatic Premium Payment (complete Section D)

**B. Please choose from the options below for your initial premium payment:**

Paper Check\*                       Electronic Check (complete Section E)

If you choose one of these two options, you will receive a bill every two or three months thereafter, depending on the billing frequency you select.

Select Frequency:  Bimonthly     Quarterly

**C. Monthly Credit/Debit Card**

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

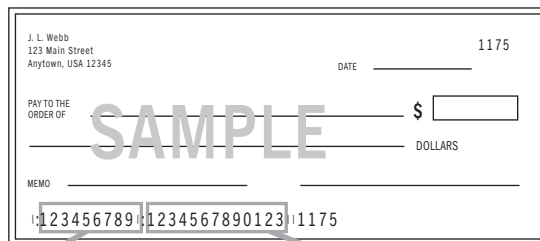
We accept Visa, MasterCard, Discover and Star\*.  
 \*For Star, we accept 16 digit card numbers only.

Card No.: \_\_\_\_\_ Exp. : \_\_\_\_/\_\_\_\_ Cardholder ZIP Code: \_\_\_\_\_  
 (16 digits only)

Authorized Signature (As it appears on the credit card)	Cardholder Name (As it appears on the credit card) PRINT	Date
X		

**D. Monthly Checking Account Automatic Premium Payment**

By providing your check information to the right, you authorize us to electronically debit your bank account. Your bank account will be debited one month's premium the day after approval. Subsequent premium amounts will be debited on the day you request below.



Requested Debit Day: \_\_\_\_ (1st to 28th of each month)  
 If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account numbers here. →

Bank Routing No. \_\_\_\_\_ Bank Account No. \_\_\_\_\_

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. **You will incur a \$25 service charge for any withdrawal not honored.**

Authorized Signature (As it appears in the financial institution's records)	Account Holder Name PRINT	Date
X		

**E. Electronic Check**

In lieu of sending a Paper Check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing No.	Account No.	Amount \$	Check No.

\* Enclose check for first month's payment. By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

cut or tear along dotted line ✂