Capital

## Automated Payment Options

By completing this form, I/we authorize Capital Blue Cross and its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company®, and Keystone Health Plan® Central (collectively "Capital"), and the financial institution named below, to deduct the amount of the initial deposit and/or recurring weekly/monthly fees (as indicated below) for health care coverage from our account on the designated day and transfer such amount directly to Capital. If the designated day is a holiday, the payment will be deducted on the next business day. I/We agree to maintain sufficient funds in the account to permit these deductions. If the account does not have sufficient funds at the time of transfer, I/we understand that our Capital health care coverage may be denied/cancelled or delayed.

Please select the first 2 boxes if you are using your banking information for both **eCheck—Initial Deposit and for Recurring Auto Withdrawal.**

☐ **eCheck—Initial Deposit— ONE TIME PAYMENT ONLY**

- Select this option if you are new to Capital Blue Cross and would like to make your initial deposit through eCHECK.

☐ **Recurring Auto Withdrawal**

Select this option if you would like to sign up for recurring auto withdrawals directly from your bank account.

- ASO groups—***withdrawn weekly*** (monthly administrative fee and claims expense).
- Fully insured groups/Small Business ASO groups—***withdrawn monthly*** (monthly premium/fee on your designated due date).

☐ **Change Bank Account Information**

Select this option if you would like to change your current bank account information.

☐ **Cancel Recurring Auto Withdrawal**

Select this option if you would like to cancel recurring auto withdrawals.

- **NEW GROUPS**—please keep a copy for your records and return the original document with your new group paperwork.
- **EXISTING GROUPS**—please keep a copy of the completed form for your records and return the original document to the USPS mailing address below.

  Capital Blue Cross—Group/Corporate Check it Out
  PO Box 772612
  Harrisburg, PA 17177-2612

**NOTE:** Capital Blue Cross will notify you when enrollment into this program has been processed and the date automatic payments are set to begin. Until that time, you will receive an invoice and are responsible for payment.

You will continue to receive invoices:

- To show the balance due that will be transferred.
- To serve as a record of enrollment for the billing period (groups should verify accuracy upon receipt).
- To list the claims processed and invoiced for the billing period (ASO groups only).

## Group Information (Please Print)

Group name (As it appears on your bill/invoice) | Group # | Subgroup #

Group policymaker's name | Phone number

Group address (Street, City, State, ZIP Code)

Authorized signature | Date

Does your banking information below apply to all subgroups? ☐ Yes ☐ No

- If no, an additional form will need to be completed for each subgroup using different banking information.

## Financial Institution (Please Print)

Please check one:

☐ Checking account
☐ Savings account

Name of financial institution | ABA routing number **(nine-digit number)**

Name on bank account (if different than group name) | Bank account number

$_____
Amount of first month's initial deposit to be withdrawn, if applicable