Fill out and return

Easy$Pay authorization form (Medicare Supplement plans)

I am: ☐ A new Medicare Supplement plan Easy$Pay applicant

☐ A current Easy$Pay user reporting a change in my bank or account number (please note this change requires 30 days for processing)

Subscriber information

Subscriber name	Subscriber number	
Mailing address		Daytime phone number
City	State	ZIP

☐ By checking this box, I agree to receive electronically all communications related to my Easy$Pay account.

Subscriber email address

Debit date: ☐ 1st of month ☐ 15th of month

Note: If you're sending a voided check, you don't need to complete the account information.

Type of account: ☐ Checking ☐ Savings

Bank routing/transit number	Bank account number
Name of financial institution	Branch telephone number

Name(s) on bank account

Branch address

City	State	ZIP

Send this form to:
Blue Shield of California
PO Box 3008
Lodi, CA 95241-1912

Fax form to: (844) 266-1850

Email form to:
MSInstall@blueshieldca.com

Authorization and signature(s)

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date, and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I understand that charges may occur two to three days prior to the payment date indicated on this form. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record, and I will be responsible for making my payment by check or money order, along with a returned item service charge.

Notice to change/cancel required

I will continue to be debited/charged the amount of dues/premium owed until I cancel this automatic payment authorization upon at least 10 calendar days' notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 248-2341** [TTY: **711**]. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form, and I acknowledge that I have received a copy of this form (if the bank account is a joint account, all account holders must sign). I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Account holder signature	Print name
Social Security number	Date
Signature	Print name
Social Security number	Date

Keep for your records

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Social Security number	Date
Signature	Print name
Social Security number	Date