Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross Blue Shield Association

North Dakota Medigap Electronic Funds Transfer (EFT) Authorization

Blue Cross Blue Shield of North Dakota (BCBSND) is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts we want to encourage members to use our Electronic Funds Transfer (EFT) program, where your premium is automatically deducted. This decreases the number of paper bills being generated and makes it simple and convenient for you to keep your health coverage active. If you select the EFT option of paying for your BCBSND health insurance, the payment will be drafted on the 5th of the month, or the following business day in the case of a weekend or holiday. This will provide several advantages to you:

- Your payment will always be made on time (if funds are available in your account).
- You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- Claims will be paid promptly due to your policy always being paid current.

GETTING STARTED IS EASY by mail or phone:

1. **Complete**, date and sign the EFT authorization information below.
2. **Attach** your voided check (not a deposit slip). *If you are using a savings account, please provide proof of ownership of the account.*
3. **Return** to Blue Cross Blue Shield of North Dakota (PO Box 1106 Lewiston, ID 83501).
4. **For your convenience**, you or the bank account holder (if someone other than yourself is paying the premium) may also contact our office at 833-220-7909 to set up EFT over the phone.

If more than one month's premium is due upon first draft, do you authorize BCBSND to pull all amounts? ☐ Yes ☐ No

Policyholder Name _____ Member ID Number _____

AUTHORIZATION TO MY BANK

☐ Personal Checking ☐ Personal Savings ☐ Business Checking ☐ Business Savings

I authorize BCBSND to charge my bank account for monthly premiums due on or after the coverage effective date. I also authorize my bank to honor these monthly charges. This authority remains in effect until I revoke it in writing and provide notice to BCBSND. I understand and acknowledge that the amount debited may change based on the premiums due under my plan, and I authorize BCBSND to debit such amounts as permitted by applicable law. This authorization remains in effect until I revoke it in writing to the address on this form and provide notice to BCBSND at least five (5) business days before the proposed effective date of termination. I understand my financial institution can answer questions about my rights.

Financial Institution	Transit/Routing Numbers	Account Number

► _____

Account Holder's Name (please print)

_____ (mm/dd/yyyy)

Account Holder's Authorized Signature(s) - as it appears on bank records — Date