An independent licensee of the Blue Cross & Blue Shield Association

Automatic Payment Withdrawal

Name: ______________________________ Daytime Telephone Number: ____________________

Address: ____

Benefit Plan Number: __________________________ Requested Effective Date: ________________

Name of Financial Institution: ____

Address of Financial Institution: ____

ABA (bank routing) Number: ____________________ Account Number: ____________________

Checking ❑ Savings ❑ Is this a business account: Yes ❑ No ❑

I hereby authorize my Financial Institution to deduct the current premium from my checking or savings account and remit the same to BCBSND. This authorization is to continue in effect until revoked by me in writing. I understand a 30-day notice is needed when canceling an automatic withdrawal authorization. BCBSND is not responsible for overdrafts and fees due to insufficient funds in my account.

Date: ____________________ Signature: ______________________________

Please attach a voided check and return to
Blue Cross Blue Shield of North Dakota, 4510 13th Ave S, Fargo, ND 58121.