BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Interoffice use only

REP B#:	DATE:
PP:	DATE:

Group One-Time and Automatic Monthly Payment Authorization

Please complete the information below:

Company Name:	Billing Account Number (BAN):
Company Billing Address:	
City:	State: / Zip:
Phone:	Email:
Company Name on Account:	Bank Name:
Bank Account Number:	Routing Number:

This Business Bank Account is Enabled for ACH Transactions ☐ **YES** ☐ **NO**

I certify that I am an authorized signer on the specified account and an Authorized Employer Representative with respect to this transaction. I instruct this financial institution to permit this deduction. I understand this payment will be deducted through an ACH debit to the specified deposit account.

I understand that BCBSAL will make only one attempt to deduct this payment from the deposit account. If the payment cannot be processed for any reason, BCBSAL will not make additional attempts to deduct this payment. I will be responsible for initiating another online payment or providing another form of payment. Any fees charged by my financial institution are my responsibility.

Please select payment type(s): One-Time Payment **and/or** Automatic Monthly Payment

☐ One-Time Payment Agreement

One Time Payment Amount:

$

_____ By initializing here, I authorize Blue Cross and Blue Shield of Alabama to **deduct** ACH debits per my request by phone to the deposit account identified above.
This does not authorize automatic monthly payments.

I hereby authorized BCBSAL to deduct the payment specified from the deposit account with the financial institution identified above. If this is an initial binder payment for the set-up of a new group, it can take two or more business days for the payment to be processed. If this initial payment exceeds the first month's premiums, the excess amount will apply to the following month's bill.

☐ Automatic Monthly Payment

I authorize BCBSAL to deduct my group's total premium on a monthly, recurring basis from the deposit account with the financial institution identified above. I understand that my recurring payment will be deducted on the due date of each bill. I understand that I may revoke my authorization for these recurring payments by contacting Blue Cross at the telephone number on my group invoice or by canceling online. In order to stop the next scheduled payment, Blue Cross must receive my notice at least one business day prior to the scheduled payment date. Both my authorization and the Blue Cross recurring payment will remain in full force and effect until revoked by me, my financial institution or by Blue Cross. Please refer to your monthly invoice or log into Group Access (under Account Management) to verify if your account has been set up on automatic monthly draft.

I have read and agree to the Payment Authorization. ***Please include copy of voided check when submitting form.***

Name (Please print)

Signature: ***Date Signed :*** ***Title:***

Email: GroupEnrollPayments@bcbsal.org Fax: (877) 532-9413 toll free

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