

Sure Pay Authorization Form

Save the hassle of writing us a check.

With Sure Pay, there's no bill to keep track of. No check to write. And nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account.

Just complete and sign this authorization form. Mail or fax it to us, and we'll handle all the details with your bank.

Please note that your first monthly premium may be deducted after your normal payment due date. If the first deduction is delayed, it may be for more than one monthly premium.

Complete and sign form, then mail or fax to: Enrollment Services, Blue Cross Blue Shield of Arizona
P.O. Box 13466, Phoenix, AZ 85002-3466 • Fax (602) 864-4041

Person to be billed:

Last name First Initial

Address City State ZIP code

Daytime phone

Pay your premiums the convenient way with Sure Pay!

Please debit my: Checking account Savings account

Routing transit number

Account number

If applicant is different from person to be billed, provide information on applicant below:

JOHN DOE 123 Any Lane Anywhere, USA 12345		Date _____	123
Pay to the ORDER OF _____		s. <input type="text"/>	
MEMO _____			
:0101010101:	.0101010101	123	
Routing Number	Account Number	Check Number	

Name Blue Cross Blue Shield of Arizona ID No.

Important: Remember to sign the authorization below.

I authorize Blue Cross Blue Shield of Arizona (BCBSAZ) to start an automatic periodic charge to my checking or savings account as noted on this form. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.

I want this charge to continue automatically until I write BCBSAZ telling them to discontinue my Sure Pay service. I agree to allow a reasonable time for discontinuance of Sure Pay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Sure Pay withdrawals.

I understand BCBSAZ and my financial institution have the right to discontinue this service if either elects to do so.

I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month or twice the amount the following month. My BCBSAZ coverage will be terminated if there are insufficient funds in two consecutive drafts.

I have read and agree to abide by the Sure Pay conditions as outlined on this authorization form.

Authorized signature on account Date