Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Group Authorization Agreement for Automatic Payments

Group name:			Group decision maker:	
BCN group ID:	Subgroup ID:	Street address:		
City:		State:	Zip code:	Telephone number:

Authorization for automatic payments

I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my group's checking/savings account amounts necessary to pay the premium owed by my group under my group's BCN contract. This authority will remain in effect until I, or another group representative, notifies you, or the bank listed below, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation.

Bank name:	Branch:	
City:	State:	Zip code:

Please deduct my monthly BCN premium from (check one):

☐ Checking account (Include a voided check when you return this form.)

☐ Savings account (Include a voided deposit slip when you return this form.)

If you bank online, please write in your checking or savings account number and bank routing number.

Account number ______________________________

Bank routing number __________________________

Signature of group decision maker:	Date:

We'll send you written notification of the date your automatic payments begin. After that, withdrawals will occur automatically each month on the date your premium payment is due.

Fax: 1-866-615-6793

Email: bcnaccountsreceivable@bcbsm.com

Mail: Blue Care Network
Collections – Mail Code C415
P.O. Box 5043
Southfield, MI 48086-5043

Blue Care Network use only

Processor:	Process date:	Effective date: