Wellmark Blue Cross Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

Individual Automatic Payment Authorization Form

This form cannot be used for group policies. Group administrators must log on to www.wellmark.com to enroll in automatic payment.

YES! I authorize Wellmark Blue Cross and Blue Shield of Iowa and/or Wellmark Health Plan of Iowa, Inc. to make automatic withdrawals from the account shown on the enclosed ***voided check*** or ***deposit slip*** in the amount of my periodic premium payment and service fee, if applicable, as they may be adjusted from time to time.

My authorization for free automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any service fee assessed by my bank for stop-payment orders that I make.

I may cancel my automatic payment or provide new/updated banking information any time by notifying Wellmark in writing by the 10th of the month prior to my next scheduled withdrawal. ***If my request is not received by the 10th of the month prior to my next scheduled withdrawal, I will be responsible for any fee assessed by my bank for insufficient funds.***

If I miss the 10th of the month deadline, to stop a payment on my next scheduled withdrawal,I must notify my bank no less than three (3) business days before the next scheduled withdrawal. ***I will be responsible for any fee assessed by my bank for stop-payment orders that I make.***

If at any time my account falls behind in payments, I understand Wellmark reserves the right to withdraw any amount necessary to bring my account current with the next regularly scheduled automatic payment. Wellmark will not withdraw any amount above that which is due at the time of withdrawal; notice may not be provided to me prior to said withdrawal.

I understand that, if my premium payment is for COBRA continuation coverage, my payment frequency must be monthly. All other policy types may have different payment frequency options available to them. This authorization supersedes and replaces any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature X_____ **Date X**_____/_____/_____

Please complete both sides of this form - **Failure to complete and return both pages will result in delays**

Return **both pages** of this completed form via fax to 515-376-9063 or mail **both pages** to:

Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232, Station 4W688
Des Moines, IA 50306-9232

Individual Automatic Payment Authorization Form

(Continued)

Member's Name: X _____

Member Address: _____

Member address cannot be updated from this form

Member DOB: _____/_____/_____ **Member's Wellmark SSN or ID: X** _____

Financial Institution Name: _____

Bank Account Holder's Name: _____

Select a payment frequency*:

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

COBRA premiums will be set as monthly even if another frequency is selected

Select the day of the month:

☐ 1st of the month ☐ 5th of the month

☐ Checking ☐ Savings State Code*: _____

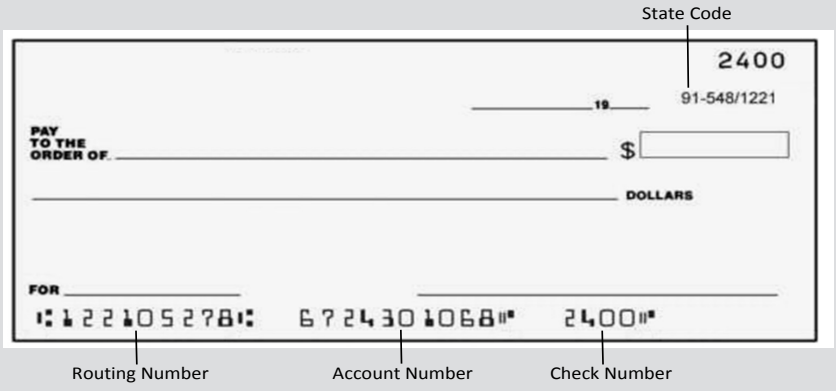
Routing #*: _____ Bank Account #*: _____

*Not sure where to find this information? Please see the box below for an example.

VOIDED CHECK REQUIRED

To assist us in processing your request, please tape voided check in this area

If you are using a savings account, please tape voided deposit slip in this area



Please complete both sides of this form - **Failure to complete and return both sides will result in delays**

Questions?

Visit www.wellmark.com or call Customer Service at the number listed on your Wellmark ID card