Anthem

Monthly Bank Draft / Electronic Funds Transfer Authorization (Optional)

You can choose to have Anthem automatically deduct your premium and any state-mandated fees if applicable ("payment") from your checking account each month. Once your application is approved, your Electronic Funds Transfer Account (EFT) will be set up within 30 days from your effective date. Until the service is effective, Anthem will mail your bill for your monthly payment. To set up EFT, simply complete this section and be sure to include your first month's payment, or fill out the Initial Payment Only Credit Card Payment section below, when you return your completed application.

Bank Name	Name(s) on Bank Account
Your Bank's Routing Number	Your Bank's Account Number

I authorize Anthem Blue Cross and Blue Shield (listed on bank statement as Rocky Mountain Hospital and Medical Service, Inc.) to deduct my monthly payment due each month. The amount deducted each month will be a consistent amount unless there is a rate increase or change in state-mandated fees, where applicable. If there is an outstanding balance forward due, plus my regular payment due, I will be asked to provide authorization to allow for the entire amount to be deducted. This agreement remains in effect until Anthem Blue Cross and Blue Shield receives a 30-day advance written notice from the Bank Account holder or subscriber. In the event the Bank does not pay my payment for any reason, I understand that I am responsible for such payment. Failure to make full payments when due may result in termination of my coverage.

Signature (Exactly as it appears on bank records)	Date:

INTERNAL USE ONLY

AUTO ID#	SUBSCRIBER #	EFFECTIVE DATE

Initial Payment Only Credit Card/Debit Card Premium Payment (Optional)

You may choose to make your **initial** premium payment by check, money order or credit card/debit card. Credit card/debit card payment is available for your first premium payment only. **All subsequent payments will be made through monthly bills.**

If choosing to pay by credit card/debit card, you must complete ***all*** of the following information: Credit Card Debit Card

VISA MasterCard

Card# _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ $_____

Expiration Date: (mm/yyyy) MaximumPremium Amount Authorized

I authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any difference in premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	Cardholders name (If different than applicant. Please Print)
Cardholder Signature:	Date:

INTERNAL USE ONLY: DO NOT WRITE BELOW THIS LINE

IPAD auto ID#	Subscriber #
Date Processed:	Processed by:

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