



**Authorization Agreement for Automatic Payments**

Subscriber name:		Subscriber address:	
City:	State:	Zip code:	Subscriber telephone number:
<b>Authorization for automatic payments</b>			
<p>I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my checking/savings account amounts necessary to pay the premium owed by me under my BCN contract. This authority will remain in effect until I notify 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.</p>			
Bank name:		Branch:	
City:	State:	Zip code:	
<p>Please deduct my monthly BCN premium from (check one):</p> <p><input type="checkbox"/> Checking account (Please include a voided check when you return this form.)</p> <p><input type="checkbox"/> Savings account (Please include a voided deposit slip when you return this form.)</p> <p>If you bank online, please write in your checking or savings account number and bank routing number.</p> <p>Account number _____</p> <p>Bank routing number _____</p>			
Signature:			Date:

Requests received by the 5th of the month will take effect the following month. Withdrawals will occur each month on the date your premium payment is due. We will send you written notification of the date your automatic payments begin.

<b>Blue Care Network use only</b>		
Member's contract number:	Process date:	Effective date:

**Mail To:** Blue Care Network  
IAA/Billing Department - Mail Code C415  
P.O. Box 5043  
Southfield, MI 48086