



# Individual Automatic Payment Authorization Form

This form cannot be used for group policies. Group administrators must log on to [www.wellmark.com](http://www.wellmark.com) to enroll in automatic payment.

**YES!** I, the Bank Account Holder, authorize Wellmark Blue Cross and Blue Shield of Iowa and/or Wellmark Health Plan of Iowa, Inc. and/or Wellmark Blue Cross and Blue Shield of South Dakota to make automatic withdrawals from the account shown on the enclosed **voided check** or **deposit slip** in the amount of the periodic premium payment and related fees, if applicable, as they may be adjusted from time to time as described in the Application completed by the Member.

This authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless it is canceled as described below. If Bank Account Holder calls the bank to stop payment, Bank Account Holder may be required to provide the bank a written request within fourteen (14) days after the call. Bank Account Holder will be responsible for any service fee assessed by the bank for stop-payment orders. Wellmark may also charge Bank Account Holder a returned payment fee of \$25 for any automatic withdrawal that is not honored by the bank.

The Member may cancel automatic payment or provide the Member's new/updated banking information any time by notifying Wellmark in writing or by calling the number on the Wellmark ID card by the 10th of the month prior to the next scheduled withdrawal. A Bank Account Holder other than the Member must provide written notification by the 10th of the month prior to the next scheduled withdrawal in order to cancel automatic payment or provide new/updated banking information. If the request is not received by the 10th of the month prior to the next scheduled withdrawal, request may not be processed before the next withdrawal. **The Member or Bank Account Holder will be responsible for any fee assessed by the bank for insufficient funds or stop-payment orders made.**

If at any time the Member's account falls behind in payments, Wellmark reserves the right to withdraw any amount necessary, including fees, to bring the Member's 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 either the Member or the Bank Account Holder prior to said withdrawal.

If the premium payment is for COBRA continuation coverage, the payment frequency must be monthly. All other policy types may have different payment frequency options available. This authorization supersedes and replaces any previous authorization given by the Member and/or the Bank Account Holder for automatic premium withdrawal.

Bank Account Holder's Signature _____	Date ____/____/____
Member's Signature _____	Date ____/____/____

**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: \_\_\_\_\_

Member's Address: \_\_\_\_\_

*Member address cannot be updated from this form*

Member's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member's SSN or Wellmark ID: \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_

Bank Account Holder's Name: \_\_\_\_\_

If the Account Holder's Name is different from the Member's Name, please check the appropriate box below:

- The Account Holder is an Indian tribe, tribal organization, urban Indian organization, or state and federal government program grantee. If so, **please attach** supporting documentation.
- The Account Holder is a private, not-for-profit foundation. If so, **please attach** the defined criteria that are used to determine whether the Member named above is eligible for premium payments by the Account Holder.
- Other. Please describe the relationship between the Account Holder and the Member (further information may be requested):

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:

1<sup>st</sup> of the month  5<sup>th</sup> 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.*

- Yes  No Will you be paying the premium through a business account? (If yes, answer 2 and 3.)
- If submitting a business check, are you an employee of the business paying the premium?  
 Yes  No (If yes, we cannot accept a business check for payment; a personal check must be submitted.)
- Will your premium payments for this coverage be deducted on your federal income tax return other than the special health insurance deduction available to self-employed persons?  
 Yes  No (If yes, we cannot accept a business check for payment; a personal check must be submitted.)

**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

The diagram shows a check with the following fields labeled:

- State Code:** 2400
- Routing Number:** 122105278
- Account Number:** 6724301068
- Check Number:** 2400

Other visible text on the check includes: "PAY TO THE ORDER OF", "DOLLARS", and "FOR".

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

**Questions?**

Visit [www.wellmark.com](http://www.wellmark.com) or call Customer Service at the number listed on your Wellmark ID card