BlueCross BlueShield of Montana

ezBlue℠ PAYMENT OPTION

Authorization Agreement

Take these simple steps for easy monthly premium payments:

- Verify with your financial institution that it can accept automated electronic withdrawals.
- Complete, sign and return this authorization form.

To submit this form by fax, fax **855-426-5344**.

To submit this form by mail, use this address:

Blue Medicare Supplement℠
c/o Member Services
P.O. Box 3897
Scranton, PA 18505

If you have any questions about this program, call Customer Service toll free at **855-520-1577**.

AGREEMENT

I request and authorize Blue Cross and Blue Shield of Montana and/or its designee to obtain payment of amounts becoming due, by initiating charges to my account in the form of checks, share drafts or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This authorization will remain in effect until I notify Blue Cross and Blue Shield of Montana or the Financial Institution in writing to terminate this authorization and Blue Cross and Blue Shield of Montana or the Financial Institution has a reasonable time to act on the termination.

Complete the following section in Print or Type

Deduct ongoing monthly premium payments from my designated checking or savings account. If the withdrawal date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. (Please note that coverage cannot be issued until the first month of premium has been received in our office, unless you have authorized Blue Cross and Blue Shield of Montana to deduct the initial payment upon receipt of your application).

Member ID: _____

Name of Member: _____

Name of Depositor(s) if other than the member: _____

Phone number of Member/Depositor: _____

Name of Bank, City and State
where account is authorized: _____

_____

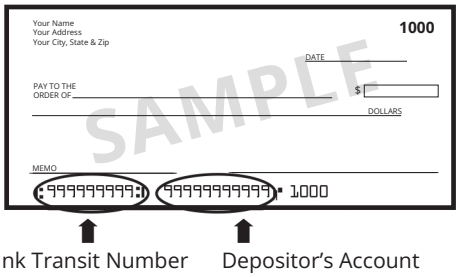
Please check one: ☐ Checking Account ☐ Savings Account

Bank Transit Number: _____

Depositor's Account Number: _____

I have read and accept the above agreement.

Please continue to pay your premiums by check or money order until you receive a confirmation letter from us stating the date automatic payments will begin.



Bank check – bottom left corner

Bank Transit Number

Depositor's Account

Depositor's Signature: _____ Date: _____

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

352142.0324

Medicare Supplement Insurance Plans are offered by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.