



AUTHORIZATION FORM

Note: 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.

MEMBER'S NAME			
ADDRESS			
CITY	STATE	ZIP	
MEMBER ID NUMBER (From your Blue Cross and Blue Shield of New Mexico ID Card)			

To pay your *future* premiums on a monthly basis, you must authorize Blue Cross and Blue Shield of New Mexico to automatically deduct the amount of your monthly premiums from your checking or savings account (with automatic withdrawal feature). To enroll in our convenient **E-Z BlueSM Payment Option** program, simply do the following:

1. Complete all of the information below.
2. Include a voided check. Please do not staple. Deposit slips cannot be processed.
3. Keep the yellow copy of this form for your records.
4. Return the white copy of this form, along with your voided check, in the enclosed postage-paid envelope.

It's that easy! Our E-Z Blue Payment Option is the fast, convenient, secure way to pay your premiums each month. No check writing or mailing payments! Reduce the chance of your policy being canceled for non-payment.

Blue Cross and Blue Shield of New Mexico will automatically withdraw the amount of your future monthly premiums directly from your account on your premium payment due date. Please note when your withdrawal date falls on a weekend or a bank holiday, the withdrawal will be processed on the next business day. If you wish to cancel your enrollment in the E-Z Blue Payment Option, please contact our Customer Service Department at least 10 working days prior to the next withdrawal date. You may re-enroll after 6 months.

If you have any questions about this program, please call our Customer Service Department toll-free at **1-800-307-8144**.

E-Z BLUE AUTOMATIC PAYMENT OPTION AUTHORIZATION

I authorize Health Care Service Corporation (Blue Cross and Blue Shield of New Mexico) to instruct my financial institution to make my monthly premium payments on the dates due from the account listed below. This authority remains in effect until Health Care Service Corporation has received notification from me of termination in time to allow reasonable opportunity to act on it, or until Health Care Service Corporation has sent me written notice of termination of this agreement.

Please print clearly

NAME OF BANK ACCOUNT OWNER	<input type="checkbox"/> ORIGINAL REQUEST TO ENROLL IN E-Z BLUE <input type="checkbox"/> CHANGE TO MY EXISTING E-Z BLUE INFORMATION
DAYTIME PHONE OF ACCOUNT OWNER	
MEMBER'S TELEPHONE NUMBER	

Financial Institution Information

NAME OF INSTITUTION	SIGNATURE OF ACCOUNT OWNER	DATE
PHONE NUMBER OF BANK OR CREDIT UNION	X	
For Home Office Use Only:		

PLEASE INCLUDE A VOIDED CHECK ONLY. DEPOSIT SLIPS CANNOT BE PROCESSED. PLEASE DO NOT STAPLE.

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

CONSUMER MARKETS

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