

## Easy Enrollment

This process may take up to four weeks.

Please contact our Member Services number at **1-800-926-6565** for additional information. (TTY users should call 1-800-955-8770.) You will be able to speak to someone from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 through February 14, except for Thanksgiving Day and Christmas Day. However, from February 15 to September 30, you will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day. Member Services also has free language interpreter services available for non-English speakers.

You may revoke the Automatic Payment Option by notifying us and your financial institution 15 days prior to the date your premium is due.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc. (BCBSF). Florida Blue HMO is a trade name of Health Options, Inc., an HMO subsidiary of BCBSF. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. Florida Blue is a PPO and PRRO plan with a Medicare contract. Florida Blue HMO is an HMO plan with a Medicare contract. Enrollment in Florida Blue or Florida Blue HMO depends on contract renewal.

1. Complete the attached Authorization Form. If you have a joint account that requires two signatures, both individuals must sign the Authorization form.
2. Attach a voided check from your checking, savings or credit union account. Withdrawals cannot be made from a mutual fund brokerage or passbook account.
3. Complete the Authorization Form and enclose your voided check or deposit slip in the attached pocket. Fold brochure, moisten, seal and place in the mail.

## Here's how it works:

When you enroll in the Automatic Payment Option, we'll deduct your premium on the date it is due.

**Exception:** If your date is the 1st, your payment will be deducted on the 3rd.

Please allow up to four weeks for completion of the automatic deduction set-up process.

If you receive a bill during this time, please pay it as you normally would. Your records will be updated to include the payment.

## The worry-free way to pay your bills.



## Take advantage of convenience, security and savings with our Automatic Payment Option.

**Convenience** – Have your premium automatically withdrawn from your checking or savings account monthly. You'll never have to worry about missing a payment.

**Savings** – You'll save time, postage and trips to the mailbox.

**Security** – Only you can authorize the Automatic Payment Option. Plus, you can ensure your payment won't get lost in the mail.

66226-0714

NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE UNITED  
STATES

### BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO 227 JACKSONVILLE FL

POSTAGE WILL BE PAID BY ADDRESSEE

FLORIDA BLUE  
MEDICARE ADVANTAGE MEMBERSHIP AND BILLING DEPT  
PO BOX 45296  
JACKSONVILLE FL 32232-9839

Medicare Advantage  
plan members...

Do something better  
with your time.



Sign up for our  
**Automatic Payment Option.**

**Florida Blue**   
In the pursuit of health®

Florida's Blue Cross and Blue Shield Plan

# Automatic Payment Authorization Form

Please attach voided check or savings account deposit slip.

\_\_\_\_\_  H            
Member Name Member ID Number (numeric portion only)

Is the Account Holder the same as the Applicant? ( ) Yes ( ) No

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

Address of Financial Institution: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Account holder name: \_\_\_\_\_

Account holder address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Bank routing number: \_\_\_\_\_

Bank account number: \_\_\_\_\_

Account type: ( ) Checking ( ) Savings

I/We hereby authorize Blue Cross and Blue Shield of Florida, Inc. (D/B/A Florida Blue) to initiate debits to, and the financial institution identified above to debit that amount to my/our account indicated. This authority will remain in effect until cancelled by me/us or the financial institution identified, with my/our consent. I/We understand that by revoking the Automatic Payment Option for payment of my/our health care coverage, my/our billing will revert back to monthly billing of premiums. This authorization is automatically revoked upon cancellation of my/our coverage. I may revoke the Automatic Payment Option by notifying you and my financial institution 15 days prior to the date my premium is due.

Account holder signature: \_\_\_\_\_

Account holder signature: \_\_\_\_\_

If the applicant and the account holder are not the same, you may be asked to provide legal documentation of the account holder's authority to initiate recurring payments from this account (i.e. voided check, letter from financial institution, etc.). During this time, please remit payment for any paper bills you may receive.

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H5434\_66226 0714  
S5904\_66226 0714  
R3332\_66226 0714

**Please tear off and keep for your records**

Date form mailed: \_\_\_\_\_

Voided Check No.: \_\_\_\_\_

Account debited from: \_\_\_\_\_

We appreciate your patience as we process your Automatic Payment information. Please continue paying your Florida Blue bill as usual until you receive a confirmation letter from us.



In the pursuit of health™

Florida's Blue Cross and Blue Shield Plan

(over, please)

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