BlueCare Dental Bank Draft Form

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Enroll in Arkansas Blue Cross and Blue Shield's Pre-authorized Monthly Bank Draft Program!

- *No checks to write, no bills to keep, no stamps to buy.*
- *Bills are paid even when you're away from home.*
- *Never risk a lapse in coverage.*
- *This service is provided at no cost to you.*

Here's How to Sign Up ...

1. Complete the information requested below.
2. Since we need information on your check, please attach a blank check from the account from which you want payment taken. Be sure to write "void" on the check before mailing it.
3. Complete the authorization form below and return to Arkansas Blue Cross and Blue Shield, P.O. Box 2181, Little Rock, AR 72203-2181, along with voided check **and** application.
4. If payment is to be withdrawn from an account other than yours, the person making your payments should follow the above directions.

IMPORTANT: PLEASE READ AND COMPLETE THIS SECTION.

I authorize Arkansas Blue Cross and Blue Shield, a Mutual Insurance Company, and the BANK* indicated below, to debit my Arkansas Blue Cross and Blue Shield premium from my checking account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK'S termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my Arkansas Blue Cross and Blue Shield coverage, UNLESS Arkansas Blue Cross and Blue Shield has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

Bank Name ______________________________

Location ______________________________ Account No. ______________________
City Zip

Insured's Name ______________________________

Insured's Address ______________________________
Street Apt. No.

____
City State Zip

Signature ______________________________ Date ______________________
Signature of Account Holder

*BANK also applies to Savings and Loan.

REMEMBER TO ENCLOSE A VOIDED CHECK WITH REQUEST.

FOR OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

I.D. NO.	GROUP NO.	EFFECTIVE DATE	AMOUNT	STATUS