Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL
From Checking or Savings Account

Submit this form to have your Health Advantage premium payments automatically deducted from your checking or savings account. Submit one form for each applicant.

Health Advantage member name and enrollment ID number (located on your ID card)			
Account Holder Name		Telephone Number	
Street Address	City	State	ZIP Code

Please deduct my monthly **Health Advantage** premium from my **(check one of the following)**:

☐ Checking account (voided check must be attached)

☐ Savings account (deposit slip must be attached)

I authorize **Health Advantage** to withdraw the premium I owe from my checking or savings account. This automatic withdrawal will remain in effect unless I notify **Health Advantage** in writing to cancel. I understand it will take time for both **Health Advantage** and my bank to cancel this withdrawal after I request it. **Please attach either a voided check for checking withdrawal or deposit slip for a savings withdrawal.**

Please allow up to four weeks to process your application. Please pay any premium bill you receive while your application is processed. **Do not send your premium payment with this form. Please send your payment to the address on your payment coupon.**

If any information is missing, we will return this form to you for completion. For questions regarding this form, please contact our Customer Service at 1-877-349-9335 (TTY users should call 711.) October 1 through March 31, hours are 8 a.m. to 8 p.m. Central time, seven days a week. From April 1 through September 30, hours are 8 a.m. to 8 p.m. Central time, Monday through Friday.

Please mail this form to: Health Advantage
PO Box 3648
Little Rock, AR 72203

Fax to: 1-501-301-1927