

Electronic Payment Option Plan

Enrollment Instructions — Group

As a Blue Cross & Blue Shield of Rhode Island (BCBSRI) group, you can choose to have your group's monthly premium payment deducted automatically from your group's checking account.

Please note: The Electronic Payment Option is only available to groups purchasing health and/or dental coverage directly with BCBSRI. If you purchased coverage through HealthSource RI, please call 1-855-651-7873 for information about payment options.

The Electronic Payment Option is easy to set up. To authorize BCBSRI to withdraw the monthly payment from your group's checking account, simply follow these steps:

- 1. Complete the Electronic Payment Option form.**
- 2. An authorized signer must sign and date the form.**
- 3. Attach a voided check for verification of all financial institution information.**
- 4. Return the completed form and voided check to:**

**Membership Dept. –EPO –Group
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699**

You will receive a monthly premium bill notifying you of your group's premium amount due. The payment will be automatically deducted from your group's bank account on the fifth business day of the month that premiums are due. Proof of payment will appear on your group's bank statement and the next month's premium bill.

You will be asked to select a new premium billing cycle to ensure that you are notified at least 10 days before the payment date. If the notification is less than 10 days before your next premium is due, your group will not be charged a premium until the fifth day of the following month. At that time, your group will be charged for both the premium for the prior month and the premium for the current month.

If your group's bank account does not have enough money on the day of the electronic payment, the bank will notify BCBSRI, and we will remove your group from the Electronic Payment Option Plan. Please note that your group insurance coverage may be canceled if the premiums are not paid by the last day of the month.

You can stop the Electronic Payment Option Plan at any time. The authority you give to charge your group's bank account will remain in effect until you notify BCBSRI or your financial institution otherwise, allowing a reasonable time for action on such request.

If you have any questions, please call our Membership Call Center at (401) 459-2341 ext. 6064 or 1-800-639-3718 ext. 6064 (outside Rhode Island). You can reach us Monday through Friday, 8:15 a.m. to 4:30 p.m.

Electronic Payment Option Form Authorization by Groups for Direct Payment

I authorize Blue Cross & Blue Shield of Rhode Island (BCBSRI) to withdraw monthly electronic premium payments from my checking account. I also elect to have my group bill issued on either one of the following days:

Please check box:

Ten days prior to the billing month **OR** Fifteen days prior to the billing month

I understand that I will receive a bill notifying me of the premium amount due. I also understand that because I have chosen the Electronic Payment Option Plan, the premium amount due will be deducted from my bank account on the fifth business day of the month that premiums are due. I acknowledge that the origination of Automated Clearing House (ACH) or electronic debit transactions to my bank account must comply with the provisions of United States law. This authority will remain in effect until I cancel it.

I understand that if my bank account does not have enough money on the day of the electronic payment, I will be removed from the Electronic Payment Option Plan. I also understand that my insurance coverage may be canceled if my payment is not paid by the last day of the month.

Company Name (Please print): _____

First Name, Last Name, and Title (Please print): _____

Group/Subgroup Identification Numbers: _____

**Please note: if you have special EFT requirements, please contact the Membership Call Center.*

Telephone Number including Area Code: _____

Financial Institution Name (Please print): _____

Financial Institution City and State: _____

Financial Institution Routing/Transit Number: _____

Financial Institution Account Number: _____

Authorized Signer: _____ Date: _____

Please attach a voided check or deposit slip indicating bank routing/transit number and bank account number to this form.