



Automatic Withdrawal Authorization Form

Policyholder Name _____ Effective Date ____/____/____

Policyholder SSN or Wellmark ID _____ Policyholder Date of Birth ____/____/____

- New Enrollment Update to an existing policy
- Automatic account withdrawal from policyholder's account
- Automatic account withdrawal from account other than the policyholder's

Select a payment frequency*:

- Monthly Quarterly Semi Annually Annually

*COBRA premiums will be set as monthly even if another frequency is selected.

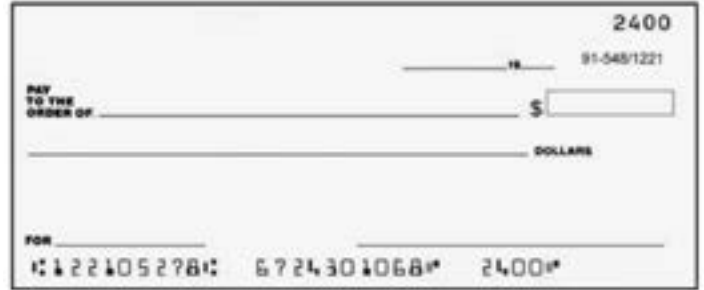
Select the day of the month:

- First of the month Fifth of the month

Select Bank Account Type:

- Checking
- Savings

Provide your Routing and Account Numbers here:



9-Digit Bank Routing Number

Bank Account Number

AUTOMATIC WITHDRAWAL AUTHORIZATION

I authorize Wellmark to initiate electronic debits to my bank account. I understand this authorization will apply to all products selected on any Wellmark application form. I understand that, depending on the timing of when my application is received and processed, Wellmark reserves the right to withdraw the appropriate amount necessary (including multiple months of payments) to bring my account current with the next regularly scheduled automatic payment. If at any time the policyholder's account falls behind in payments, Wellmark reserves the right to withdraw any amount necessary, including fees to bring the account current with the next regularly scheduled automatic payment. Wellmark will not withdraw any amount above that which is due at the time of withdrawals. Notice may not be provided to me prior to this withdrawal. I understand and agree that I will not receive a paper billing statement but that I have the option to view my bill on Wellmark.com prior to my chosen withdrawal date, and I can also choose to subscribe to receive an email notification when a new billing statement is available which will include my withdrawal amount.

I further understand and agree that the automatic withdrawal amount will change periodically to correspond with the applicable premium and fees. My authorization for automatic withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make. I may also be charged a returned payment fee of \$25 for any automatic withdrawal that is not honored by my bank.

I understand that I can cancel automatic payment or provide updated banking information any time by notifying Wellmark in writing or by calling the number on the Wellmark ID card by the 10th of the month prior to the next scheduled withdrawal. A bank account holder other than the policyholder must provide written notification by the 10th of the month prior to the next scheduled withdrawal in order to cancel automatic payment or provide updated banking information. If the request is not received by the 10th of the month prior to the next scheduled withdrawal, the request may not be processed before next withdrawal. The policyholder or bank account holder will be responsible for any fee assessed by the bank for insufficient funds or stop payment orders made.

Wellmark does not accept premium payment from anyone other than the primary policyholder unless made by (1) a parent, Power of Attorney or legal guardian paying for a policy covering only a dependent(s); (2) Indian tribes, tribal organizations, urban Indian organizations; or (3) state or federal government programs or grantees. Additional supporting documentation may be requested. State and federal law prohibits an employer from contributing to the payment of an employee's premiums for this plan unless the applicant is the sole proprietor or owner of a sole proprietorship or the premium is being paid by the employer through after tax wage adjustment or payroll deduction.

Bank Account Holder's Name (as it appears on the account) _____

Authorized Signature of Bank Account Holder _____

Date of signature ____/____/____

Submit to: Wellmark Blue Cross Blue Shield of Iowa
 PO Box 9232 Station 4W688
 Des Moines, IA 50306-9232
 OR
 Fax: 515-376-9063

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.