



# 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.

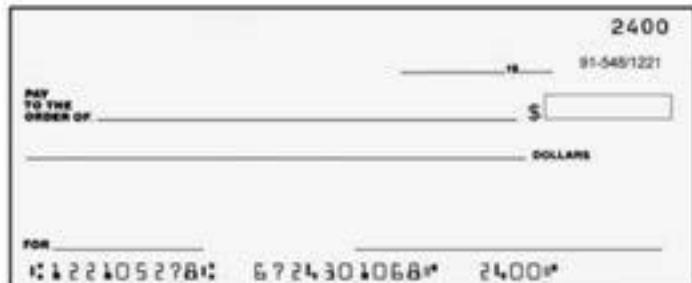
Select the day of the month:

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

# **Required Federal Accessibility and Nondiscrimination Notice**



**Discrimination is against the law**

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

## **Wellmark provides:**

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call 800-524-9242.

**ATENCIÓN:** Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打  
800-524-9242 或（听障专线：888-781-4262）。

**CHÚ Ý:** Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

**NAPOMENA:** Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242

**تُنْبِهُ: إذا كنت تتحدث اللغة العربية، فلأنا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٦٢٢-٧٥١-٣٣٤٦**

ສໍາ່ງຄວນເອົາໃຈໃລ້, ພາສາລາວ ຖ້າທ່ານເວັບ: ພວກເຮົາມີບໍລິການຄວາມຂ່ວຍເຫຼືອດ້ານພາສາ  
ໃໝ່ຂ່າຍໄວ້ໂປ່ງເປົ້າ ທີ່ 800-524-9242 ສິນຕິທີ່ (TTY: 888-781-4262 )

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें: अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email [CRC@Wellmark.com](mailto:CRC@Wellmark.com). You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Geb Acht: Wann du Deitsch schwetze duscht, kannsch du Hilf in dei eegni Schprooch koschdefrei griige. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรายังคงบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่ต้องคำนึงถึงภาษา ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyo tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

**ВНИМАНИЕ!** Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телефон: 888-781-4262).

የሰነድ የሚከተሉ ነው፡ የአዲስ አበባ ቤት የኢትዮጵያ አገልግሎቶች፡ ከዚህ ነው፡  
82ኛውን ዓ. 800-524-0242 መጠሪ (011) 888-781-1262) ወጪውን ተደርጓል፡፡

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajilooni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

**УВАГА!** Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телефайп: 888-781-4262).

Ge': Diné k'ehjí yáñiltí'go níka bizaad bee áká' adoowot, t'aa jiik'é, náhóló. Kojí' hólne' 800-524-9242 doodai' (TTY: 888-781-4262)