Individual Automatic Payment Authorization Form

This form cannot be used for group policies. Group administrators must log on to www.wellmark.com to enroll in automatic payment.

YES! I, the Bank Account Holder, authorize Wellmark Blue Cross and Blue Shield of Iowa and/or Wellmark Health Plan of Iowa, Inc. and/or Wellmark Blue Cross and Blue Shield of South Dakota to make automatic withdrawals from the account shown on the enclosed ***voided check*** or ***deposit slip*** in the amount of the periodic premium payment and related fees, if applicable, as they may be adjusted from time to time as described in the Application completed by the Member.

This authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless it is canceled as described below. If Bank Account Holder calls the bank to stop payment, Bank Account Holder may be required to provide the bank a written request within fourteen (14) days after the call. Bank Account Holder will be responsible for any service fee assessed by the bank for stop-payment orders. Wellmark may also charge Bank Account Holder a returned payment fee of $25 for any automatic withdrawal that is not honored by the bank.

The Member may cancel automatic payment or provide the Member's new/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 Member must provide written notification by the 10th of the month prior to the next scheduled withdrawal in order to cancel automatic payment or provide new/updated banking information. If the request is not received by the 10th of the month prior to the next scheduled withdrawal, request may not be processed before the next withdrawal. **The Member or Bank Account Holder will be responsible for any fee assessed by the bank for insufficient funds or stop-payment orders made.**

If at any time the Member's account falls behind in payments, Wellmark reserves the right to withdraw any amount necessary, including fees, to bring the Member's account current with the next regularly scheduled automatic payment. Wellmark will not withdraw any amount above that which is due at the time of withdrawal; notice may not be provided to either the Member or the Bank Account Holder prior to said withdrawal.

If the premium payment is for COBRA continuation coverage, the payment frequency must be monthly. All other policy types may have different payment frequency options available. This authorization supersedes and replaces any previous authorization given by the Member and/or the Bank Account Holder for automatic premium withdrawal.

Bank Account Holder's Signature _____ **Date** _____/_____/_____

Member's Signature _____ **Date** _____/_____/_____

Please complete both sides of this form **- Failure to complete and return both pages will result in delays**

Return **both pages** of this completed form via fax to 515-376-9063 or mail **both pages** to:

Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232, Station 4W688
Des Moines, IA 50306-9232

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

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Individual Automatic Payment Authorization Form

(Continued)

Member's Name: _____

Member's Address: _____

Member address cannot be updated from this form

Member's DOB: _____/_____/_____ **Member's SSN or Wellmark ID:** _____

Financial Institution Name: _____

Bank Account Holder's Name: _____

If the Account Holder's Name is different from the Member's Name, please check the appropriate box below:

1. ☐ The Account Holder is an Indian tribe, tribal organization, urban Indian organization, or state and federal government program grantee. If so, ***please attach*** supporting documentation.
2. ☐ The Account Holder is a private, not-for-profit foundation. If so, ***please attach*** the defined criteria that are used to determine whether the Member named above is eligible for premium payments by the Account Holder.
3. ☐ The Account Holder is my employer. (If yes, answer a and b below)
   a. Are you a sole proprietor purchasing coverage only for yourself, yourself and spouse/dependents, and not purchasing coverage for any common law employee?
      ☐ Yes ☐ No
   b. Is your premium being paid by your employer through after-tax wage adjustments or payroll deductions?
      ☐ Yes ☐ No
   Note: If you answered "no" to a and b, your employer should consider sponsoring a small employer health plan.
4. ☐ Other. Please describe the relationship between the Account Holder and the Member (further information may be requested):

   _____

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:

☐ 1st of the month ☐ 5th of the month

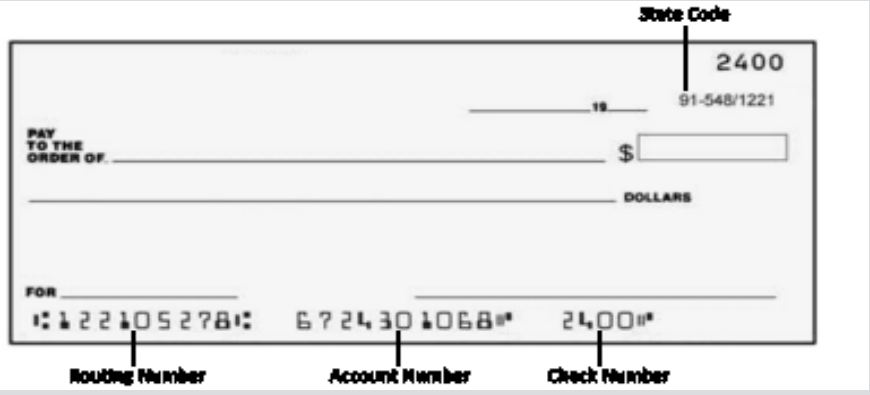
☐ Checking ☐ Savings

Routing #*: _____ Bank Account #*: _____

*Not sure where to find this information? Please see the box below for an example.

VOIDED CHECK REQUIRED

To assist us in processing your request, please tape voided check in this area
If you are using a savings account, please tape voided deposit slip in this area



Please complete both sides of this form - <u>Failure to complete and return both sides will result in delays</u>

Questions?

Visit www.wellmark.com or call Customer Service at the number listed on your Wellmark ID card

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.

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. 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.

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 osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي : 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 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, निःशुल्क 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).

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

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

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

တ၀်ဒုးသ့ဉ်ညါ–နမ့်ကတိၤကညီကျိာ်.ကျိာ်တ်မၤစၤတ်ဖံးတ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.အိဉ်လၢနဂီၢ်လီၤ. ဆဲးကျိးဆူ၀၀–၅၂၄–၉၂၄၂မ့တမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ာ်.

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

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 መደም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

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

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni 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 (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Synergy Health, 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.

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