BlueCross BlueShield of New Mexico

Auto Bill Pay

Automatic Premium Payment Authorization Agreement

NOTES:

- Do not use this form if you purchased a plan through bewellnm.com. Contact the New Mexico Health Insurance Exchange.
- For you to enroll in Auto Bill Pay, we must have your email address.

For convenient monthly premium payments, first confirm your financial institution accepts automated electronic withdrawals. Then to sign up, you can:

Go to **bcbsnm.com**, log in to Blue Access for Members℠, and go to Make a Payment.

Or, mail this form to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 660819
Dallas, TX 75266-0819

If you need help with this form or have questions, please call Customer Service toll-free at **866-445-1396**.

How Auto Bill Pay Works

Withdrawal Timing and Sufficient Funds

- Payments are due on the last day of the month before the month of coverage.
- If the payment date falls on a non-business day or a holiday, the payment will be taken on the next business day.
- If a payment is denied for non-sufficient funds, Blue Cross and Blue Shield of New Mexico (BCBSNM) may try to process the charge again at any time in the next 30 days.
- BCBSNM will not pay you back for any fees my bank or credit union charges you for not having enough money in your account.

Company checking accounts may not be used unless:

- You have the authority to approve this payment agreement,
- The company is not paying any portion of this premium directly or by paying you back, and
- The company is not deducting any part of the premium from your pre-tax income under section 106 or section 162 of the Internal Revenue Code.

Go online or complete the agreement on page 2.

Automatic Premium Payment Authorization Agreement

Please complete the following:

Name of member/applicant: ______________________________

BCBSNM member ID/applicant's Social Security number: ______________________________

Name of depositor(s) if other than the member/applicant: ______________________________

Phone number of member/applicant (or depositor if different): ______________________________

Email address (REQUIRED): ______________________________

Name of bank and city and state where account is authorized:

____

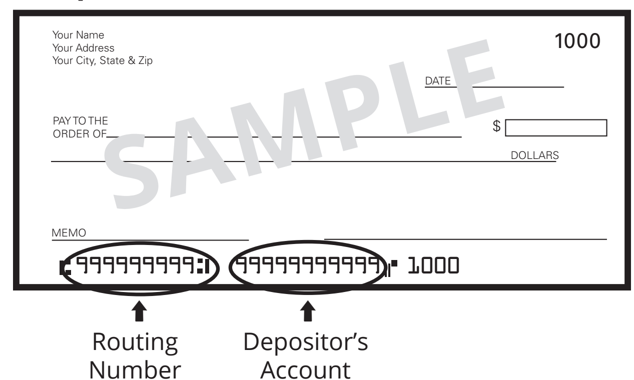
Please check one: ☐ Checking account ☐ Savings account

Routing number: ______________________________

Depositor's account number: ______________________________

Deduct ongoing monthly premium payments only from my checking or savings account. ☐ Yes ☐ No

Sample Bank check



- Please make sure you have enough money in your account when you submit this Agreement.
- Both the bank or credit union and BCBSNM reserve the right to end this payment program or your participation in it if payment is denied for non-sufficient funds. This means payments would not be made automatically anymore. Coverage may stop (claims would not be paid) if you do not pay your monthly bill.
- To change the bank or credit union these payments are paid from, you will need to give at least 10 days notice to BCBSNM by telephone before a scheduled payment date.

NOTE: Please continue to pay your premiums until you receive a confirmation letter from us stating the date automatic payments will begin.

I confirm that I want BCBSNM and/or its designee to automatically withdraw monthly premium payments from my checking or savings account (named above). Withdrawals will occur on the last business day of the month before the next month of coverage. If the last usual business day (any Monday through Friday) of the month is a holiday or other nonbanking day, I confirm payment will be withdrawn on the next business day. Withdrawals may be in the form of checks, share drafts or electronic debit entries. I also confirm that I want my financial institution named here to honor the same payments from my account.

I have read and accept the above agreement.

Depositor's signature: ______________________________ Date: ______________