ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

8. *Payment Method* Premium payment required. First payment will be credited to approved applicants only. By sending your check to us, you authorize Blue Cross of California to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

8A. Checking Account Automatic Premium Payment

☐ **Monthly checking account deduction premium payments**

Name of Bank or Financial Institution: ____________________

Account No.: ____________________ Bank Routing No.: ____________________

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. **You will incur a $25 service charge for any withdrawal not honored**.

Authorized Signature *(As it appears in the financial institution's records)*	Date
X	

8B. Credit Card **FAX to: (800) 327-9255**

☐ **Initial premium (For new member's Medical and Dental fees only)** ☐ **Monthly premiums**

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. Credit Card: ☐ VISA ☐ MasterCard ☐ Discover

Card No.: ____________________ Exp.: _____ Cardholder's Zip Code _____ – _____

Cardholder's Name *(As it appears on the credit card)* PRINT	Authorized Signature *(As it appears on the credit card)*	Date
X	X	

8C. Billing (To be used if an automatic payment option is NOT selected from 8A or 8B above.)

☐ **Bi-monthly** (Submit 2 months premium) ☐ **Quarterly** (Submit 3 months premium)

TO BE COMPLETED BY YOUR BLUE CROSS-APPOINTED AGENT

1. Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? .... ☐ Yes ☐ No
   If yes, please attach explanation.
2. Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? .... ☐ Yes ☐ No
   If no, please explain: ____________________
3. I verify that this application was completed by the applicant unless the Statement of Accountability was completed.

Signature of Agent *(Required)*	Date *(Required)*
X	

4. **Breakdown of funds collected:**
   - Total Medical funds $ __________
   - Total Dental funds $ __________
   - **Total funds collected** $ __________
5. Was the Term Life Insurance option selected? *(If yes, first Term Life Insurance payment will be billed.)* .... ☐ Yes ☐ No

Name of Agent (Print Name)		Agent's Street Address Suite No./Personal Mail Box (PMB) No.	
Jack J. Mowers, CLU, ChFC		26741 Portola Parkway Suite 514	
Agent ID No. DNKLGLSQRZ	Sub-Agent ID No. –	City/State/ZIP Code Foothill Ranch, CA 92610	Location No.
Phone No. 949-454-2994	FAX No. 949-454-2997	E-mail Address jackmowers@hotmail.com	

Mail Service Agreement to: ☐ Agent ☐ Primary Applicant

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the primary applicant.

Mailing address:

Agent: Please mail this application to the following address:
Blue Cross of California • P.O. Box 9041 • Oxnard, CA 93031-9041

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