

Electronic Funds Transfer (EFT) Authorization Form

Please complete this form, then mail or fax it to the address or fax number below. Please allow 30-60 days for your EFT to become effective. In the meantime, continue to mail your group's premium payments to avoid cancellation.

Anthem Blue Cross and Blue Shield
P.O. Box 5208
Denver, CO 80217
Fax: 303-831-3391

On behalf of _____ (Group), I authorize Rocky Mountain Hospital and Medical Service Inc., d/b/a Anthem Blue Cross and Blue Shield, or its subsidiary company, HMO Colorado, to withdraw premium payments and any other related amounts permitted by the Employer Master Contract from the account indicated below and authorize the Financial Institution named below to debit such amounts from Group's account.

Enrollment Type: <input type="checkbox"/> New <input type="checkbox"/> Revised	Effective Date:
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Financial Institution Information

Financial Institution Name:			
Financial Institution Street Address:	City:	State:	ZIP Code:
Account Number:	Bank ABA Number:		
Account Type: <input type="checkbox"/> Checking/NOW <input type="checkbox"/> Savings <input type="checkbox"/> Other If other, please specify:			

PLEASE ATTACH A VOIDED CHECK/DEPOSIT SLIP.

Group Information

Group Name:			
Anthem Blue Cross and Blue Shield Group Number:			
Group Street Address:	City:	State:	ZIP Code:
Group Contact Person:			Phone Number:

This authorization shall remain in full force and effect until Anthem receives 30 days' advance written notice of termination from the Financial Institution or Group's authorized representative. If the Financial Institution rejects payment of Group's insurance premiums for **any** reason, I understand that Group remains liable for payment of all insurance premiums. Failure to remit premiums when due may result in termination of Group's policy.

Printed Name:	Authorized Signature on This Account:	Date:
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For Anthem Blue Cross and Blue Shield Use Only

Authorized Anthem Blue Cross and Blue Shield Signature:	Date:
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