

**FEDERAL**  
PRE-EXISTING CONDITION  
INSURANCE PLAN

**Pre-Authorized Monthly Bank Draft Program**

1. Complete the information requested below.
2. Since we need information on your check, please attach a blank check from the account from which you want payment taken. BE SURE TO WRITE "VOID" ON THE CHECK BEFORE MAILING IT.
3. Complete the authorization form below and return to BlueAdvantage Administrators along with voided check and application.
4. Please allow approximately 30 days to establish the pre-authorized draft. If you get a bill during this time, please pay it as you normally would.
5. You will receive a notice showing when deductions will begin.
6. If payment is to be withdrawn from an account other than yours, the person making your payments should follow the above directions.

***After we receive your Authorization Form and voided check, we will change your payment method to the Bank Draft Program. You will be notified by letter of the effective date of your first draft.***

**IMPORTANT: PLEASE READ AND COMPLETE THIS SECTION.**

I authorize BlueAdvantage Administrators, a third party administrator, to initiate debits to, and the BANK\* indicated below, to debit the amounts to my checking account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK'S termination of this agreement.

**I understand that, by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my PCIP coverage, UNLESS BlueAdvantage Administrators has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.**

**Bank Name** \_\_\_\_\_

**Location** \_\_\_\_\_ **Account No.** \_\_\_\_\_  
City Zip

**Insured's Name** \_\_\_\_\_ **PCIP ID #** \_\_\_\_\_

**Insured's Address** \_\_\_\_\_  
Street Apt. No.  
\_\_\_\_\_  
City State Zip

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
Signature of Account Holder

\*BANK also applies to Savings and Loan

**REMEMBER TO ENCLOSE A VOIDED CHECK WITH REQUEST.**