Small Group initial payment form

(1 - 100 employees)

Step 1 - Complete group information

Company name

Address		Suite #
City	State	ZIP code

Phone # (XXX) XXX-XXXX	Company contact e-mail address

Step 2 - Complete bank information

Bank name

Account holder name

Routing #	Checking account #

Step 3 - Choose Payment Option

Initial payment only - ☐ One-time withdrawal for first month's payment

Premium amount to be debited: $ _____

Recurring payment (AutoPay) - ☐ Withdraw statement balance amount two days before the due date

If selecting AutoPay, the first payment will be based on the first billing statement balance amount. It can be as much as a 2-month premium due to the effective date and billing cycle. Recurring payment amount changes based on the current outstanding premium for the given month.

Step 4 - Sign Authorization

Automatic debit form authorization and signature

I authorize Blue Shield to initiate a debit to the bank account shown above. This electronic debit should be completed within three days before or after my group's plan effective date to pay the first month's dues/premium for members covered by Blue Shield. If selected, recurring payments occur monthly two days before the due date. I also authorize my financial institution to reduce the balance of my group's account by the amount shown (and/or corrections to previous debits). If this item is returned unpaid, I authorize Blue Shield to mail a bill to the address on record, and the group will be responsible for making the payment by check or money order and for paying any return item service charges for coverage to become effective. I understand that Blue Shield of California will appear on bank statements as California Physicians' Service. By signing, I agree to the terms and conditions of this authorization form and acknowledge that I have received a copy of this form.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Authorized Representative's Name	Phone # (XXX) XXX-XXXX
Signature	Date Signed (MM/DD/YYYY)