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

☐ Checking ☐ Savings	Routing #	Account #

Step 3 – Initial payment

Initial premium amount to be debited: $

First payment must be 70% or more of initial premium amount.

Step 4 – Monthly payments

☑ **Set up recurring payments (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 will include any true-up variance from the initial payment amount. Recurring payment amount changes based on the current outstanding premium for the given month.

☐ **Monthly bill** - Pay online via Employer Connection portal or by mail each month.

Step 5 – 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 will be processed monthly, two business days before the first of each month. 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)