BlueCross BlueShield Nebraska

ATTN: Accounting
PO Box 3248
Omaha, NE 68180
DebitAuth@nebraskablue.com

# Medicare Supplement Medicare Advantage Debit Authorization

If the bank account to be used belongs to an employer or third-party, please use form 50-128.

| First Name: | MI: | Last Name: | Member ID Number: |
|---|---|---|---|
| | | | |

| Address (Street, City, State, ZIP + 4 Code, County): | Phone Number: |
|---|---|
| | |

## DEBIT AUTHORIZATION

I authorize Blue Cross and Blue Shield of Nebraska (BCBSNE) to initiate debit entries (charges) to my account at the financial institution named below and charge the said account. The amount and timing of such debit entries (charges) may be changed from time to time by BCBSNE by giving me written notice in advance of any change.

This authority is to remain in full force and effect until the financial institution and BCBSNE have received written notification from me of its termination in such time as to afford the financial institution and BCBSNE a reasonable opportunity to act on it.

If coverage is a Medicare Supplement plan, I authorize my account to be charged on the 20th of every month for the following month's premium and any prior balance.

If coverage is a Medicare Advantage plan, I authorize my account to be charged on the 1st of every month for the month's premium and any prior balance.

Additional payment options and future account changes can also be made via myNebraskaBlue.com.

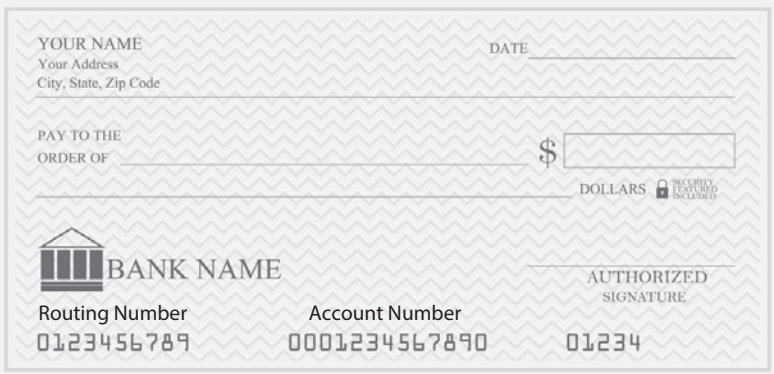
Signature _____ Date _____

***Please complete the bank and account information below:***

Name of Bank: _____ City, State: _____

Account Number: _____ Type of Account: ☐ Checking ☐ Savings

Routing/ABA Number: ☐☐☐☐☐☐☐☐☐




**ATTACH A VOIDED BLANK CHECK FOR OUR RECORDS**

**FOR SAVINGS ACCOUNTS, ATTACH A BANK LETTER**