Electronic Funds Transfer (EFT)

Save up to $24 per year!

Horizon Blue Cross Blue Shield of New Jersey has the tools you need to help manage your health care. Enjoy the convenience of the automatic payment system, and save money on your Medicare Supplement plan monthly premium. With EFT, your monthly payments will automatically be deducted from your checking or savings account depending on your bill frequency selection (monthly, quarterly, semi-annually).

When you sign up for this service, you can save $2.00 off the total monthly rate. Plus, you'll save on the cost of checks and postage, and you won't have to worry about making your payment on time if you travel or become ill.

Here's how to sign up:

1. Fill out the request on the back of this letter.
2. Return the request with your plan application or mail it to:

   Horizon BCBSNJ
   Medicare Supplement Correspondence
   PO Box 10138
   Newark, NJ 07101-3147

Your automatic payment effective date:

If you are submitting this request with your enrollment application, your automatic payment start date will be your plan effective date.

Important!

Include your email address on the form. We will send you confirmation emails at the time of payment and alert you of any changes or issues.

(See reverse to authorize your EFT)

HorizonBlue.com

EFT Authorization Request:

I allow Horizon Insurance Company (a subsidiary of Horizon Blue Cross Blue Shield of New Jersey), hereafter named Horizon, to take monthly withdrawals, for the then-current monthly rate, from the account named on this form. I also allow the named banking facility (Bank) to charge such withdrawals to this account.

Withdrawal amounts will be for the total payment due. This authority is active until Horizon and the Bank receive notice from me to end withdrawals in enough time to give Horizon and the Bank a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the Bank in such time as to give the Bank a reasonable opportunity to act upon it. I understand that such action may make the health care insurance premium past due and subject to cancellation.

Member Name		
Member ID Number (if available)		
Member Email Address		
Member Address		
City		
State		
ZIP Code		
Bank Information:		
Bank Name (Optional)		
Bank Routing Number		
Bank Account Number		
Bank Account Type	❑ Personal Checking ❑ Personal Savings	❑ Business Checking ❑ Business Savings
Name on the Account		
Bank Account Holder's Signature		
Date		