AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS

INSTRUCTIONS:

1. Please complete authorization card.
2. Please enclose a **VOIDED CHECK** for bank number verification.
3. **TO STOP YOUR DRAFT OR CANCEL YOUR POLICY YOU MUST NOTIFY US 15 DAYS PRIOR TO YOUR DRAFT COMING OUT OF YOUR ACCOUNT.**

COMPANY NAME: Blue Cross and Blue Shield of South Carolina and/or Companion Life COMPANY ID NUMBER: 320396492

I hereby authorize Blue Cross and Blue Shield of South Carolina and/or Companion Life to initiate debit entries to my Checking Account below and the Bank named to debit my account.

BANK NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

BK TRANSIT/ABA NO. _____ MY ACCOUNT NUMBER _____

This authority is to remain in force until the Bank has received written notification from me of its termination in such time and in such manner as to afford the Bank a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to the Bank prior to charging account. If an erroneous debit entry is initiated by the COMPANY to a customer's account, customer shall have the right to have the amount of such entry credited to such account by the Bank, if, within 15 calendar days following the date on which the Bank sent to customer a statement of account or a written notice pertaining to such entry or 46 days after posting, whichever occurs first, the customer shall have sent to the Bank a written notice identifying such entry, stating that such entry was in error and requesting the Bank to credit the amount to such account.

SOCIAL SECURITY # _____

YOUR NAME _____ and/or POLICY # _____

DATE _____ SIGNED _____