

CIGNA Medicare Rx® (PDP)

Medicare Part D Prescription Drug Plans



Recurring Direct Debit Authorization Form

ONLY complete if you want your premium automatically deducted from your bank account. DO NOT complete both sides of this form.

Member Name: _____

Member ID Number: _____

Type of Account: Checking Savings

If you are using a checking account, you MUST tape ONLY a voided check here.
If you are using a savings account, you MUST tape ONLY a voided deposit ticket here.
DO NOT attach both. This will insure accuracy in processing your request.

Thank you.

I hereby authorize Connecticut General Life Insurance Company (my CIGNA Medicare Rx (PDP) plan sponsor) to deduct from my bank account listed above the amount of my monthly CIGNA Medicare Rx (PDP) premium as stated in my Evidence of Coverage. This deduction will occur once per month and will continue as long as I am enrolled in the CIGNA Medicare Rx (PDP) plan or until I select another payment method. If the monthly premium amount changes, I will be notified in writing prior to any changes in the amount deducted from my bank account.

Account Holder Signature: _____

Today's Date: _____ / _____ / _____

MAIL THIS COMPLETED AND SIGNED FORM TO:

CIGNA Medicare Rx (PDP)

PO Box 269005

Weston, FL 33326-9927

Or Fax to 1-800-735-1469

Questions Call: 1-800-222-6700 TTY/TDD Users Call: 1-800-322-1451

8:00 am - 8:00 pm, local time, 7 days a week.

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Recurring Credit Card Authorization Form

ONLY complete if you want your premium automatically charged to your credit card.
DO NOT complete both sides of this form.

Member Name: _____

Member ID Number: _____

Credit Card Type: VISA Master Card

Credit Card Number:

Credit Card Expiration Date: _____ / _____
Month Year

Cardholder Name (as it appears on your Credit Card): _____

Cardholder Billing Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize Connecticut General Life Insurance Company (my CIGNA Medicare Rx plan sponsor) to charge my credit card listed above the amount of my monthly CIGNA Medicare Rx premium as stated in my Evidence of Coverage. This charge will occur once per month and will continue as long as I am enrolled in the CIGNA Medicare Rx plan or until I select another payment method. If the monthly premium amount changes, I will be notified in writing prior to any changes in the amount charged to my credit card.

Account Holder Signature: _____

Today's Date: _____ / _____ / _____

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