

Recurring Direct Debit Authorization Form

ONLY complete if you want your premium automatically deducted from your bank account.

Customer Name:	Customer ID Number:
Customer Home Phone Number: ____-____-____	Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings

TAPE VOIDED CHECK HERE

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 ensure accuracy in processing your request.

Thank you.

I hereby authorize Cigna Health and Life Insurance Company (my Cigna Medicare Prescription Drug Plan sponsor) to deduct from my bank account listed above my monthly Cigna premium amount due, and if applicable any late enrollment penalty amount due, but no more than the total of two (2) month's premium in any given month. In the event my monthly premium is lower than the expected monthly premium due to overpayments or adjustments, I authorize Cigna Health and Life Insurance Company to automatically deduct my bank account for the lower amount due. I understand this automatic deduction must go through my bank approval process. Once approved, this deduction will occur once per month and will continue as long as I am enrolled in the Cigna plan or until I select another payment method. I understand this authorization will remain in effect regardless if my annual premium changes at any time during my enrollment unless I verbally or in writing revoke this authorization. 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: ____/____/____
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MAIL THIS COMPLETED AND SIGNED FORM TO:

Cigna
PO Box 269005
Weston, FL 33326-9927
Or fax to: 1-800-735-1469

Questions call: 1-800-222-6700
(TTY users call: 711)
8am - 8pm local time, 7 days a week.
Our automated phone system may answer your call during weekends from April 1 – Sept. 30.