



Cigna Easy Pay Authorization

I hereby authorize Cigna HealthCare of Arizona, Inc. (Cigna) to debit my account at the financial institution identified below between the 5th and 8th business day of each month for my monthly Cigna premium payment. If funds are insufficient, I authorize a **double debit** to my account the following month in the amount of the two premium payments. If premium amounts change, I authorize a debit for the new amount in order of continue this service.

I understand that this authorization will be remain in effect until the earlier of (1) termination of the underlying Cigna individual plan; (2) written notice from Cigna that it will no longer collect premiums under this authorization; (3) the date Cigna is denied access to my account for any reason; (4) my revocation of this authorization, by submitting a two weeks prior written notice sent to the address set forth below; or (5) after **two** attempts to collect my premium result in insufficient funds. I understand that I can revoke this authorization and elect to pay premiums directly to Cigna upon such written notice at any time. I understand that by cancelling this service, I am not cancelling my health care coverage.

Easy Pay enrollment Easy Pay change Cancel Easy Pay

TO START EASY PAY:

- Complete and sign form.
- **Include a voided check.** (You will not be set up on Easy Pay unless it is included.)

Customer name _____ Customer ID number _____

Address _____
STREET CITY STATE ZIP

Daytime telephone # _____ Starting monthly premium amount \$ _____

Financial institution _____ Telephone # _____

Branch address _____

Account number _____ Checking Savings Share Draft

Month requested to begin Easy Pay _____

Account holder signature _____ Date _____

IMPORTANT NOTE: Signed authorizations received by Cigna before the 25th of each month will take effect the following month; those received on or after the 25th of the month will take effect the month after. (For example, an authorization received on January 27th will take effect in March). Please retain a copy of this authorization for your records and notify us immediately of any changes to the information provided above.

Mail to: Cigna
Attn: Payment Control Department
P.O. Box 29030
Phoenix, AZ 85038-9971
Phone: 1-800-973-2580 (option 1)
Fax: 623-277-1025

For Office Use Only: ABA Routing # _____ Effective Date _____