Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

CHP USE: EFFECTIVE _____

MEDICARE - SOCIAL SECURITY DEDUCTION

AUTHORIZATION AGREEMENT FOR SOCIAL SECURITY DEDUCTION

Member Name:_____ **Member ID#**_____
(please print)

I am requesting automatic deduction from my Social Security Benefit Check. Your payment amount will appear as a deduction on your benefit check. It may take a month or two to begin. If that happens, we'll send you a bill.

This deduction is to remain in full force and effect until the Plan has received written notification from the member or the Social Security Administration Office of its termination.

PREMIUMS PRIOR TO EFFECTIVE DATE NEED TO BE PAID BY CHECK

Date_____**Signature**_____

Member Services
850-383-3311

H5938_DP 372 Accepted 08282012

This form can be dropped off in person at:
1264 Metropolitan Blvd Tallahassee, FL 32312

Or

Emailed to: premiumbilling@chp.org

Or

FAX#: 850-523-5623