Health Net of California, Inc. (Health Net)

Electronic Check Form

For new business groups

Applicant information – Electronic debit payment authorization

Policyholder name: _____ **Group number:** _____ **(Health Net use only)**
(Must match the employer name on the master application)

I authorize Health Net to debit my account for the **first month's premium only** upon approval of the attached application. This payment will be electronically debited from my company bank account, using the information provided, for

Amount of premium: _____ **Financial Institution Name:** _____

Transit routing number: _____ **Account number:** _____

Employer address: _____

This transaction will appear on your next bank statement as an electronic funds transfer (EFT) transaction.

For groups wanting to set up a monthly auto-withdrawal of their premium payment, please contact Health Net Membership at 800-224-8808 for details.

If this item is returned unpaid, I authorize a returned check fee for the maximum amount as allowed by the state to be charged to this account. I also acknowledge that Health Net will not be responsible for any fees incurred if the original check is mailed and cashed.

_____

Employer signature **Title** **Date**

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