

# 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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