



Electronic Check Form

For new business groups

Applicant information – Electronic debit payment authorization

Group 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

Confidentiality note: The documents accompanying this facsimile transmission may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments.