

# Electronic Check Form

For new business groups

## Applicant information – Electronic debit payment authorization

**Policyholder name:** \_\_\_\_\_ **Group number:** \_\_\_\_\_ **(Health Net use only)**  
**(Must match the 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, based on the copy of the check below, for

**Amount of premium:** \_\_\_\_\_ **Check number:** \_\_\_\_\_

**Transit routing number:** \_\_\_\_\_ **Account number:** \_\_\_\_\_

**Checking account 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 your Health Net Account Manager 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**

## Attach copy of voided check

### IMPORTANT: DO NOT MAIL OR ATTACH ORIGINAL CHECK

The Billing Department needs the most accurate information to debit your account. Therefore, the voided check is necessary for processing. **Please note: We are unable to accept the following checks and account types:** third-party checks, credit card checks, cashier's checks, money orders, traveler's checks, official checks, government checks.

PLEASE ATTACH  
COPY OF VOIDED CHECK HERE

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