Health Net of California, Inc. and
Health Net Life Insurance Company (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 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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