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[1] to debit my account for the **first month's premium only** based on the copy of said premium check upon approval of the attached application. This payment will be electronically debited from my company bank account for **policyholder name:** ______________________________ using the information provided.

Amount of premium: ______________________ **Check number:** ______________________________

Account number: ______________________ **Transit routing number:** ___________________________

Checking account address: ____

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

If this item is returned unpaid, I authorize an additional 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.

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

[1]For purposes of this form, "Health Net" means Health Net of California, Inc., Health Net Health Plan of Oregon, Inc. and/or Health Net Life Insurance Company.

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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