



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 Net¹ 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.

Employer signature

Title

Date

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

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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