

HEALTH NET CALIFORNIA, INC.
Direct Deposit Authorization Agreement for External Broker

I authorize HEALTH NET CALIFORNIA, INC., hereinafter called COMPANY, to make payment of any amount owing me (us) by initiating credit entries into the account and at the bank listed below. This agreement will remain until I give written notice to change financial institutions, terminate service, or until COMPANY notifies me that this service has been terminated. I hereby authorize COMPANY and the financial institution to electronically deposit any payment into my designated account and to correct my account for any amounts deposited to which I am not entitled.

BROKER NAME
(As it appears on license):

VENDOR/ BROKER ID#
(Please list all ids that apply):

SSN / COMPANY TAX ID
(Of above licensed broker name):

MAILING ADDRESS:

CITY, STATE, ZIP:

PHONE #:

AUTHORIZED BY: _____ **DATE:** _____

PRINT NAME: _____ **TITLE:** _____

INSTRUCTIONS FOR DIRECT DEPOSIT

Fill in complete banking information where indicated. If routing number is unknown, please contact your bank. **Without the correct Routing Number, the automatic deposit cannot be processed and your conversion to electronic funds transfer will be delayed.**

CHECK ONE: New Direct Deposit with A/P Change Existing Deposit with A/P

BANK NAME:

ROUTING #: **ACCOUNT #:**

ACCOUNT TYPE: Checking (Please attach a Voided Bank Check)

Please Note: It takes approximately 2 weeks to implement an automatic deposit. **If you transfer to a new Bank, or if you change accounts, your automatic deposit may be interrupted.** Any question regarding this process, please contact our Broker Relations Department at 1-800-448-4411 and select option #4.

Mail or Fax this completed form to
Health Net California, Inc.
Broker Commissions Department CA-100-04-02
P.O. Box 9103, Van Nuys, CA 91409-9103
Fax # 818-676-5524