



Electronic Check Form

For new business groups

Applicant information – Electronic debit payment authorization

Policyholder name: _____ **Group number:** _____ **(Health Net use only)**
(Must match the employer 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, for

Amount of premium: _____ **Financial institution name:** _____

Transit routing number: _____ **Account number:** _____

Employer address: _____

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

The filling of this electronic check form is for the 1st month's premium amount only as a guarantee of payment. Recurring auto payments for your 2nd-month premium forward are managed via the group admin portal, please log in to manage your billing preferences there. Groups needing additional assistance with monthly auto-withdrawal setup for their premium payments should contact the service line for detailed instructions at 888-802-7001.

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

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