ELECTRONIC FUNDS TRANSFER

ADVANTAGES OF ELECTRONIC FUNDS TRANSFER

- No more hassles of writing a check each month
- No monthly coupon to mail
- Date of withdrawal is the fifth business day of the month
- No check writing charges
- Assurance that your monthly premium is paid on time

TO START THIS SERVICE, PLEASE:

1. Complete and sign (in **both** places) this *Electronic Funds Transfer Authorization Form.*
2. Return the *Electronic Funds Transfer Authorization Form* with a voided check to ensure accurate account information.
3. Mail to: Kaiser Permanente, P.O. Box 23127, San Diego, CA 92193-3127; or fax to **(858) 614-3344**.
   Submit this form only once, unless your financial account information changes.

Please continue to send in your monthly payment until you are notified by mail of the start date for electronic funds transfer. After we receive your completed authorization form, please allow 30 days for processing. Items returned by your financial institution are subject to a $25 processing fee. If you have any questions, please call **1-888-236-4490**. Representatives are available 7 a.m. to 7 p.m., Monday through Friday, 7 a.m. to 3 p.m. weekends (except holidays).

Electronic Funds Transfer Authorization Form

SUBSCRIBER'S NAME

SUBSCRIBER'S MEDICAL RECORD NUMBER

SUBSCRIBER'S ADDRESS | CITY | STATE | ZIP

FINANCIAL INSTITUTION | ROUTING NUMBER (9 DIGITS)

BANK ACCOUNT HOLDER NAME(S) | CHECKING OR SAVINGS ACCOUNT NUMBER (CIRCLE ONE)

X

SUBSCRIBER'S SIGNATURE (Use black ink only.) **DATE**

For savings or credit union accounts, please obtain the routing number from your financial institution. Attach a preprinted, voided check to this form (see below) or include a letter from your financial institution that includes the routing number, account number, account type (checking, savings, etc.), and bank account holder's name. **Deposit slips cannot be accepted.**

Authorization agreement: I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to initiate monthly transfers from my checking or savings account to pay my Health Plan premium as indicated by Kaiser Foundation Health Plan, Inc. I understand it is my responsibility to notify Kaiser Foundation Health Plan, Inc., of any changes to my bank account, and that **I can terminate the electronic funds transfer process with a 30-day written and signed advance notice**.

X

Bank account holder's signature (As shown on financial records. Use black ink only.) **Date**

Please tape down all four corners of the preprinted, **voided check** here. **Deposit slips cannot be processed.**

KAISER PERMANENTE®