

## Electronic Check Form

For new business groups

Applicant information – Electro	nic debit payment authorization	
Policyholder name:(Must match the employer name on the mas	Group number: ter application)	(Health Net use only)
•	he <b>first month's premium only</b> upon approval of th company bank account, using the information provid	• •
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) trans	action.
For groups wanting to set up a monthly aut at 800-224-8808 for details.	to-withdrawal of their premium payment, pleaso	contact Health Net Membership
	rned check fee for the maximum amount as allowed l ll not be responsible for any fees incurred if the origin	,
Employer signature	Title	Date

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