KAISER PERMANENTE®

Small Business

ELECTRONIC FUNDS TRANSFER (EFT) FOR INITIAL PAYMENT/AUTOPAY

Kaiser Permanente does not accept credit cards for initial small group coverage premium payments.

EMPLOYER INFORMATION

Company Name _____

Phone _____ Ext. _____ Fax Number _____

Billing Contact Name _____ Billing Contact Email Address _____

(This should be the individual who will manage the group's Online Bill Pay account. Once enrolled, a temporary password will be sent from kpmas@onlinebiller.com).

AUTHORIZATION

I authorize Kaiser Permanente to withdraw the debit amount from the account below:

_____

Name (as it appears on the Account)

_____

Street Address (as it appears on bank account) City State ZIP County

_____ _____

Transit Routing Number (9-Digits) Bank Account Number

Premium Debit Amount:

☐ Withdraw the amount of the first month's premium, based on the final rate verification; **OR** ☐ Indicate amount to be debited: $ _____

☐ I authorize Kaiser Permanente to enroll my account into Autopay. Monthly premium will be deducted on the 1st of each month.

If this item is returned unpaid, I authorize Kaiser Permanente to resubmit the item and charge this account an additional insufficient funds fee for the maximum amount allowed by the state as a result of a returned check.

SIGNATURE

I affirm that I have authority to contract with KFHP-MAS/KPIC on behalf of the group.

_____ _____

Authorized company signer (please print name) Title (please print)

_____ _____

Signature Date

Confidentiality note: This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information in the transmission is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments.

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