KAISER PERMANENTE®

Medical record number

Medicare Health Plan Autopay Selection Form

Use this form to set up automatic premium payments from a checking account, savings account, credit card, or debit card.

Form Instructions

1. In the **Membership Details** section, fill in your membership information.
2. Pick an Option to choose how you want to pay your premium:
   - **Option 1** withdrawn directly from your checking or savings account
   - **Option 2** use a debit or credit card
3. Sign under the Option you've selected and at the bottom of the last page.
   - Without **BOTH** signatures your autopay enrollment can't be processed.
4. After completing and signing the form, mail or fax it to us at the following address:
   Kaiser Permanente
   Membership Administration
   P.O. Box 232400
   San Diego, CA 92193-9914 Fax: **1-855-355-5334**
5. After you are enrolled, your monthly invoices will be accessible through your account at **kp.org**.
   - If you don't have an account, you can sign up at kp.org by clicking **Register** at the top right of the page. After you've registered, you can manage your delivery preferences.
   - When payments are processed, you'll receive email confirmation.

Reminders

Before submitting this form, ensure that you have completed the form accurately and provided all necessary information. Double check your form to avoid any delays in processing.

- You have completed all fields in the Membership Details section
- You have signed under your selected autopay option and the Automatic Premium Payment Agreement.
- Do not submit this form if you intend to have your premium deducted from your monthly Social Security or Railroad Retirement Board benefit check.

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Medicare Health Plan Autopay Selection Form

☐ New Autopay Request ☐ Update Current Autopay

Membership details:

All fields are required in order to proceed with autopay enrollment.

☐ California ☐ Colorado ☐ Georgia ☐ Hawaii ☐ Mid-Atlantic States ☐ Northwest

Last name of Kaiser Permanente member

First name of Kaiser Permanente member MI

Date / / Phone number - -

***Email address**

Option 1: Electronic funds transfer from checking or savings account

Electronic funds transfer (EFT) of your premium payment from a checking or savings account will be made between the first and fifth of each month. Payments returned by your financial institution are subject to a $25 processing fee.

Type of account: ☐ Checking ☐ Savings

Name as it appears on bank account (first name, middle initial, and last name)

Street address (associated with account)

City State ZIP code

Bank routing number (bottom left of check) Bank account number

Signature of account holder *(Required if choosing Option 1)*

Important note: Please continue to submit your monthly payment until you're notified by mail of the start date for your electronic funds transfer. Processing usually takes about 30 days after we receive this form.

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Option 2: Credit or debit card charges

Kaiser Permanente will charge your card between the first and the fifth of the month for the amount due on your premium payments.

☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Credit card # Expiration date /

Name of credit card account holder

Street address (associated with card)

City State ZIP code

Signature of credit card account holder *(Required if choosing Option 2)*

Note: You may also sign up online:

- Members in California, Colorado, Georgia, Hawaii, or Northwest regions may sign up at **kp.org/payonline**.
- Members in the Mid-Atlantic States region may sign up at **kp.org/mas/onlinebilling**.

Important note: Please read carefully and sign the Automatic Premium Payment Agreement below and keep a copy for your records. Failure to sign under your selected option and the Automatic Premium Payment Agreement will result in your autopay enrollment request being delayed or not processed.

Automatic Premium Payment Agreement

I hereby authorize Kaiser Permanente to initiate debit entries from my checking or savings account, or charge my credit or debit card as indicated. If the amount of an entry differs from the previous month's entry pursuant to this agreement, Kaiser Permanente shall notify me in writing of the new amount not less than 5 calendar days prior to debiting my account.

If my account is erroneously debited by Kaiser Permanente, I have the right to have my financial institution credit that amount back to my account within the dates dictated by the check acceptance rules. Should an error occur, I shall notify Kaiser Permanente in writing that an error has occurred and request that it credit my account in the amount in question.

This authorization is to remain in full force and effect until Kaiser Permanente receives my written notification of its cancellation. The cancellation must be received 30 days in advance of the date on which my account is to be debited.

Signature of member *(Required)*

This notification must be sent to:

Kaiser Permanente
Membership Administration
P.O. Box 232400
San Diego, CA 92193-9914
Fax: **1-855-355-5334**

Before submitting this form, ensure that you have completed the form accurately and provided all necessary information.
Double check your form to avoid any delays in processing.

- ✓ You have completed all fields in the Membership details section.
- ✓ You have signed under your selected autopay option and the Automatic Premium Payment Agreement above. Without both signatures your autopay enrollment can't be processed.
- ✓ Don't submit this form if you intend to have your premium deducted from your monthly Social Security or Railroad Retirement Board benefit check.