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

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