KAISER PERMANENTE®

All plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Ste. 100, Portland, OR 97232

Northwest Region electronic funds transfer authorization

Debit from checking or savings account

It's easy and convenient to pay your membership premium by authorizing Kaiser Foundation Health Plan of the Northwest (KFHPNW) to make a monthly electronic funds transfer from a checking, savings, or credit card account. Your premium payment will automatically be deducted from your bank or credit union account on the 5th of each month or the first business day after the 5th. If you select this method of payment, please fill out the next section of this form and attach a voided check or a letter from your bank or credit union with your account number and bank routing code.

☐ Checking account number _____

☐ Savings account number _____

Name of bank account holder _____ Signature of bank account holder _____

Name of bank/credit union _____ Address of bank/credit union _____

Important: If you are authorizing an automatic debit for your premium, you must attach to this form a voided check or a letter from your bank or credit union with your account number and bank routing code. Please carefully read and sign the payment agreement at the bottom of this form. You must notify your bank if the name of the account holder is different from the name of the member.

Credit card

Your premium payment will be charged automatically to your credit card each month. This charge is processed on the 20th of the month for the following month's premium. We accept MasterCard, Visa, Discover, and American Express. If you select this method of payment, fill out the next section of this form.

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Credit card number _____ Expiration date _____

Name of credit card account holder _____ Signature of credit card account holder _____

Address of credit card account holder _____

Important: Please keep a copy of this agreement for your records. Carefully read and sign the payment agreement below.

Automatic premium payment agreement

I hereby authorize KFHPNW to initiate debit entries to my checking or savings account or to charge my credit card as indicated. If the amount of an entry differs from the previous month's entry pursuant to this agreement, KFHPNW shall notify me in writing of the new amount not less than five (5) calendar days before debiting my account. If my account is erroneously debited by KFHPNW, I have the right to have my financial institution credit that amount back to my account within fifteen (15) calendar days following the date the institution provided me with a statement pertaining to the debit entry. If an error occurs, I will notify my financial institution in writing that the error has occurred and request that institution to credit my account in the amount in question. This authorization is to remain in full force and effect until KFHPNW receives thirty (30) days advance written notification of its cancellation. This notification must be sent to:

Kaiser Foundation Health Plan of the Northwest
Membership Administration
P.O. Box 203007
Denver, CO 80220-9012

Please pay premiums on the following health plan:

Health record number (if current member) _____ Subscriber name (primary account holder) _____

Date of birth or Social Security number (for ID purposes if new member) _____ Subscriber signature _____

Member (for whom payment is being made; please print) _____ Member signature _____

Date _____ Daytime telephone _____