KAISER PERMANENTE®

Health/Medical record number

Medicare Autopay Selection Form

If you'd like to set up automatic premium payments from your checking or savings account or using a credit card, you can do so with this form. Just choose your preferred payment method; complete, print, and sign the form; then mail or fax all pages back to us at the address or fax number for your area listed at the end of this form.

Option 1: Electronic funds transfer from checking or savings account

You can pay your membership premium by authorizing Kaiser Permanente to electronically transfer funds from your checking or savings account on a monthly basis. The payment will be made from your bank account between the 1st and the 5th of each month. Payments returned by your financial institution are subject to a $25 processing fee.

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. Also, you need to notify your bank if the name of the account holder differs from the name of the Kaiser Permanente member.

☐ Checking account #

☐ Savings account #

Name of bank account holder

Bank routing number (bottom left of check)

Signature of bank account holder

Option 2: Credit or debit card charges

You can also pay your membership premium by authorizing Kaiser Permanente to charge your credit or debit card on a monthly basis. The charge will be processed 10 days before the bill due date. For your convenience, we accept MasterCard, Visa, Discover, and American Express.

To schedule credit or debit card charges, you may **either** complete this form or sign up online.

To 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**.

To schedule payments using this form, please provide your card information here.

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Credit card #

Expiration date /

Name of credit card account holder

Address of credit card account holder

Email address

Signature of credit card account holder

4 5 4 2 2 9 4 9 3 1

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Health/Medical record number

Options 1 and 2: Membership details

Last name of Kaiser Permanente member

First name of Kaiser Permanente member

MI

Signature of member

Date / /

Phone number - -

Please indicate your region: California Colorado Georgia Hawaii Mid-Atlantic States Northwest

Important information

Please carefully read and sign the Automatic Premium Payment Agreement below and keep a copy for your records. Once you select this option, you'll stop receiving invoices in the mail. Instead, you'll get email notifications when your payments have been processed.

Automatic Premium Payment Agreement

I hereby authorize Kaiser Permanente to initiate debit entries from my checking or savings account or charge my credit 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 five (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 credits 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.

This notification must be sent to:

California members:

Kaiser Permanente
Membership Administration
P.O. Box 23127
San Diego, CA 92193-3127
Fax: **855-355-5334**

Colorado, Georgia, Hawaii, Mid-Atlantic States, or Northwest members:

Kaiser Permanente
Membership Administration
P.O. Box 232407
San Diego, CA 92193-9914
Fax: **866-551-9598** (CO, GA, HI, NW)
Fax: **855-414-2801** (Mid-Atlantic States)