FOR APAC OFFICE TO HELP CUSTOMER PAY MONTHLY FEE

Health Net of California, Inc.
Health Net Life Insurance Company

Health Net®

Health Net's Simple Pay Option

for Individual and Family Plans

Mail to: Health Net, Inc., PO Box 2066, Rancho Cordova, CA 95741 or **fax to:** 1-916-935-4522
Or **email to:** CAIFP.RC-MembershipAccounting@healthnet.com.

Name of Health Net member/applicant:	Subscriber ID/Reference number or Social Security number:

Simple Payment Option for Individual & Family Plans

Automatic Bank Draft (ABD)(Select one): ☐ First month's premium only ☐ Ongoing monthly premium only ☐ First month's premium AND ongoing monthly premium

Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: ☐ Checking ☐ Savings

Transit routing number (9 digits):	Account number:

Bank name:	State:

I understand that, by requesting the automatic payment option, I am authorizing Health Net of California, Inc. and Health Net Life Insurance Company ("Health Net"), and my financial institution named above, to debit my checking or savings account for my monthly premium payment(s).

I understand that the premium withdrawn from my account will be for the future billing period, plus any past due balances. I understand that my premium payments will automatically adjust if my monthly premium changes.

This authority is to remain in effect until revoked by me in writing, and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such debit. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with my bank.)***

ABD transmissions are withdrawn from my bank account on approximately the 20th of every month, for the following month's premium. I understand that if there are insufficient funds at the time my account is debited, a service fee of $25.00 (in addition to any fees my bank may charge me) will be assessed by Health Net for all dishonored payments. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the loss of health coverage.

Signature of account holder (required to process):	Date:

☐ **Credit card for first month's payment**

First month's premium can be charged directly to your credit card account. All future premiums due may be made by Automatic Bank Draft (complete the section above) or by mailing a check. **Your card will be charged for the first month's premium only.**

First name (as on card):	Middle (as on card):	Last name (as on card):	Card type: ☐ Visa ☐ MasterCard

Account number (16 digits, complete):	Expiration date (mm/yy):

Billing address:	City:	State:	ZIP[1]:

As a convenience, I request and authorize Health Net to charge my credit card account identified above for the payment of my initial premium. I understand that my first month's withdrawal charge may be for multiple periods depending upon my date of approval and the billing period. This authority is to remain in effect until revoked by me in writing, and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, **I will be charged a $25 service charge.**

Signature of credit card account holder (required to process):	Date:

[1]The ZIP code must match the cardholder's address; otherwise, the credit card cannot be processed.

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