Medicare Electronic Funds Transfer Authorization Form

You have the option of paying your membership premium electronically by authorizing Kaiser Permanente to make a monthly electronic funds transfer (or automatic premium payment) from a checking or savings account of your choice.

Your payment will automatically be deducted 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.

To select this automatic premium payment, please complete this form and mail or fax it back to us. Please continue to submit your monthly payment until you are notified by mail of the start date for an electronic funds transfer. Processing can take up to 30 days after receipt of your completed authorization form.

☐ Checking account #

☐ Savings account #

Name of bank account holder

Bank routing number (bottom left of check)

Signature of bank account holder

Important – 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 differs from the name of the Kaiser Permanente member. Please keep a copy of this agreement for your records. Carefully read and sign the payment agreement. If you elect to submit your payment via automatic premium payment, an invoice will no longer be mailed to you. Instead you will receive an email notification that your payment has been processed.

Medicare Electronic Funds Transfer Agreement

I hereby authorize Kaiser Permanente to initiate debit entries from my checking or savings account 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 my account be credited for 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:

Kaiser Permanente
Membership Administration
P.O. Box 23127
San Diego, CA 92193-3127
Fax **858-614-3344**

All other regions:

Kaiser Permanente
Membership Administration
P.O. Box 232407
San Diego, CA 92193-9914
Fax **866-614-3513** (CO, GA, HI, NW)
Fax **866-551-9598** (Mid-Atlantic States)

Please pay premiums on the following health plan:

Last name of Kaiser Permanente member

First name MI

Signature of member

Medical/Health record number Date / / Phone number - -

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

Email address

Credit or debit card option

You may also pay premiums by credit or debit card.
To sign up, visit **kp.org/payonline** (**kp.org/mas/onlinebilling** for Mid-Atlantic States).