KAISER PERMANENTE®

Kaiser Permanente Payment Selection Form

Your payment will automatically be deducted from your bank account between the 1st and the 5th of each month. If you select this method of payment, please fill out the next section of this form and attach a voided check.

☐ Checking Account # _____ ☐ Saving Account # _____

_____ _____

Name of Bank Account Holder Signature of Bank Account Holder

_____ _____

Name of Financial Institution Address of Financial Institution

Important – You must attach a voided check to this form if you are authorizing automatic premium debit. If using a savings account, please include a deposit slip or bank letter. 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.

Credit Card

Your payment will automatically be charged to your credit card on a monthly basis. This charge is processed 10 days prior to the bill due date. By selecting automatic payment you agree to **NO LONGER** receive a paper invoice. For your convenience, we will 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 # _____ 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 at the bottom of this form. If you select either of these payment methods an invoice will no longer be mailed to you.

Automatic Premium Payment Agreement

I hereby authorize Kaiser Permanente to initiate debit entries to 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 fifteen (15) calendar days following the date the institution provided me with a statement pertaining to the debit entry. Should an error occur, I shall 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 Kaiser Permanente receives thirty (30) days advance written notification of its cancellation prior to the draft date. This notification must be sent to:

HAWAII REGION

Kaiser Permanente
ATTN: Membership KPIF Correspondence
P.O. Box 203006
Denver, CO 80220-9006

FAX:
808-432-5394

_____ Enrolling into Medicare? Y or N _____

Name of Kaiser Permanente member (Please print) (circle one) Health Record # (if current member)

_____ _____ _____

Signature of Kaiser Permanente member Date Daytime phone