Health Net's Automatic Bank Draft *(ABD) Service*

Saving you time and money

We are pleased to offer our convenient Automatic Bank Draft (ABD), also known as Electronic Funds Transfer (EFT), service to our individually billed members.

Health Net's ABD service makes bill paying easier. Each monthly plan premium paid through ABD represents one less check to write and one less bill to mail. Also, if you are out of town, you enjoy peace of mind knowing your Health Net premiums will be paid.

How do I enroll in Automatic Bank Draft (ABD)?
To take advantage of this service, simply complete the authorization agreement and include a blank check from your checking or savings account and write "VOID" on it. Do not submit a deposit slip. If you do not have checks from your checking or savings account, please attach a letter from your bank with all the account and routing details.

Please note: A separate ABD authorization form must be completed for each Enrollment Application sent to Health Net. If applicants share the same bank account, please complete a separate ABD form for each applicant.

How does the ABD process work?
On or about the 6th of each month, Health Net will communicate directly with your bank to deduct the amount due for that month.

Your monthly bank statement will reflect the amount debited for your Health Net premium, and you will not receive a monthly bill while this service is in effect. Once ABD is authorized by your bank, we will send you a confirmation letter advising you of the first payment deducted from your account. Please allow a minimum of two weeks to process. Until you receive the confirmation letter, please continue to pay as you are billed.

Based on the time of the month this form is received by Health Net, it may take 1–2 billing cycles until the payment is deducted from your account. If a manual payment is received after the bank transmission has occurred (the 6th of the month), your account may be debited for more than one month's premium payment. If this occurs, your billing statement will reflect the manual and automatic withdrawal premiums, and your account will be credited. However, if you manually pay your premium (before the 6th of the month), your payment may be processed, and there will be no outstanding balance for the ABD to draft or process.

If you are returning this authorization form separately from your Enrollment Application, please complete and mail to:

Medicare Enrollment
PO Box 10420
Van Nuys, CA 91410

Please do not send payments to this address.

Health Net®
MEDICARE PROGRAMS

FRM006443EO01 (5/16)

Y0020_2017_0008 Compliance Approved 06142016

How do I cancel ABD?
To cancel your ABD service, please notify Health Net in writing at the address on the previous page, or call Member Services. *Please note that canceling ABD does not cancel your health care coverage, unless you also specify this request in your letter. You may only cancel your health care coverage* ***during specific enrollment periods****.*

If you have additional questions regarding our ABD service, please call Member Services:

For California HMO members, call 1-800-275-4737, HMO SNP 1-800-431-9007 (TTY: 711). For California PPO members, call 1-800-960-4638 (TTY: 711).

For Oregon/Washington members, call 1-888-445-8913 (TTY: 711).

For Arizona members, call 1-800-977-7522 (TTY: 711).

Hours of operation:
From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, your call will be handled by our automated phone system on weekends and certain holidays.

Health Net®
MEDICARE PROGRAMS

Health Net's Automatic Bank Draft (ABD) *Service*

Please list your Health Net plan.

(This information can be found in your *Summary of Benefits* or *Evidence of Coverage (EOC).)*

State: _____ **Plan name:** _____

TOTAL monthly premium: $_____

To start Automatic Bank Draft (ABD): Complete and sign this form. Include a **blank check** from your bank account and write "VOID" on it. **Do not** submit a deposit slip. (If you do not have checks from your checking or savings account, please attach a letter from your bank with all the account and routing details.) The **ABA routing number** is the 9-digit number located at the bottom left corner of your check, or you may call your bank for the number.

Your personal information:			
First name:	MI:	Last name:	
Home address:			
City: Calabasas		State:	ZIP:
Mailing address (if different from above):			
City:		State:	ZIP:
Home telephone: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___		Gender: ☐ Male ☐ Female	
Date of birth: (___ ___/___ ___/___ ___ ___ ___) M M / D D / Y Y Y Y		Preferred language: ☐ English ☐ Other: _____	
Medicare #:			
Subscriber #:			
Bank account #:		☐ Checking ☐ Savings	
Financial institution name:			
Branch address:			
ABA routing #:		**Attach voided check here** →	

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I hereby authorize Health Net and my financial institution named on the previous page to debit my bank account on or about the 6th of the month for the amount of my premium payment. I understand my premium amount may vary due to enrollment status changes, which may include retroactive premiums due.

I understand that if there are insufficient funds at the time my account is debited, a letter will be sent in 7 to 10 business days billing me for the amount owed. Insufficient funds on Automatic Bank Drafts are subject to a $15.00 returned item fee which will be billed.

I understand that this authorization will remain in effect until I notify Health Net in writing that I no longer desire this service.

I also understand that, by canceling this service, I will not be canceling my medical coverage unless specified in my written notification to Health Net. Once the notice is received by Health Net's Billing Department, a reasonable period of time (up to 10 business days) is required to revoke this agreement.

Print name:	
Signature:	Date: (___ ___/___ ___/___ ___ ___ ___) M M / D D / Y Y Y Y
Account holder signature:	**Date:** (___ ___/___ ___/___ ___ ___ ___) M M / D D / Y Y Y Y

Health Net complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-977-7522 (Arizona)，1-800-275-4737 (California)，1-888-445-8913 (Oregon) (TTY：711)。

SHOO KWE'É: Diné bizaad bee yáníłti'go, saad bee 'áka'e'eyeed bee 'áka'anída'awo', t'áá jíík'eh, nihá hóló. kohjį' biniiyá holne' dooleeł 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

For office use only – Confirmation of Automatic Bank Draft A/R initials: _____

Current premium amount to be debited: $_____ Date of first debit: _____

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