ELECTRONIC FUNDS TRANSFER FORM

Pacific Health Advantage
Choice • Simplicity • Affordability

Please print in black or blue ink. When you see a choice of one or more boxes, please put an X in the one that most accurately applies. Please write dates as Month/Day/Year

I HEREBY authorize Pacific Health Advantage, also known as The Health Insurance Plan of California (Pac Advantage or the program), to initiate debit transactions to my account for the payment of my monthly insurance premium(s). I understand the debit transactions will occur within four working days of the premium due date. This is for the premium which is due on the first of the following month. In the event I make any changes to my banking arrangements, I understand that I must notify the program to effect the changes for premium collection. All changes will be reported 15 days prior to the effective date of the change.

SUBMIT THIS COMPLETED APPLICATION ALONG WITH A VOIDED CHECK.

EMPLOYER INFORMATION

GROUP NUMBER

EMPLOYER'S FEDERAL TAX ID NUMBER

COMPANY NAME

DESIGNATED COMPANY CONTACT'S LAST NAME

DESIGNATED COMPANY CONTACT'S FIRST NAME

BANK INFORMATION

BANK NAME

ACTION

☐ SET-UP ☐ CHANGE ☐ CANCEL

ACCOUNT TYPE

☐ CHECKING ☐ SAVINGS

BANK ROUTING (ACH) NUMBER

BANK ACCOUNT NUMBER

AUTHORIZED SIGNATURE

DATE SIGNED

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