

**INSTRUCTIONS**

**New Group:** Return this form, along with your New Group Application (Employer Application), to your Kaiser Permanente sales representative and/or broker.

**Existing Group:** For future payments, email this form to [csc-sd-sba@kp.org](mailto:csc-sd-sba@kp.org) or fax to **855-355-5334**. To make a phone payment, call us at **800-731-4661** and choose the Payment Line option.

**Note:** Kaiser Permanente doesn't accept credit card payments for small group coverage.

**EMPLOYER INFORMATION**

Employer name		Group ID (if assigned)
Phone (     )     -	Ext.	Email

**AUTHORIZATION**

I authorize Kaiser Permanente to withdraw the amount due, based on the final enrollment, from the account below:

Bank routing number (9 digits)	Bank account number
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**INITIAL PAY**

One-time withdrawal for first month's payment based on Your Total Premium

Select one:

- Save account information for future reference  
 Do NOT save account information for future reference

**RECURRING PAYMENT**

Future autopay/recurring payment\*

Withdraw statement balance 4 days prior to due date (other options are available at [account.kp.org](http://account.kp.org) once your account is set-up).

\*If selecting autopay, the first payment will be based on the first billing statement which can be as much as 2 months, due to billing cycles. If this payment is returned unpaid, I authorize Kaiser Permanente to resubmit the payment and charge this account an additional insufficient funds fee for the maximum amount allowed by the state as a result of a returned check.

**READ AND SIGN**

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc. and Kaiser Permanente Insurance Company on behalf of the group.

Authorized company signer (please print name)	Company title (please print)
Signature <b>X</b>	Date

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