WASHINGTON REGION

# Authorization Agreement for Automated Clearing House (ACH) Payments

**All fields required in order to process form**
To ensure timely and accurate enrollment in the Electronic Funds Transfer (EFT) program, please complete this form and **email to kpwa.apachconfirmation@kp.org** or **submit by fax at 206-877-0671**.

Business name: _____

Federal tax ID number: _____

Kaiser Foundation Health Plan of Washington payee identification number (if known): _____

City: _____ State: _____ ZIP: _____

Email: _____

All ACH confirmation of funds transferred will be sent to this email address.

Check box to: ☐ Add ☐ Change ☐ Cancel

| | |
|---|---|
| Account name (please print): | Savings: ☐<br>Checking: ☐ |
| ABA/Bank transit number (9-digit routing number): | Account number: |

Financial institution name:

_____

**I hereby authorize Kaiser Foundation Health Plan of Washington to initiate ACH payments to the financial institution above:**

This authority is to remain in full force and effect during my participation with Kaiser Foundation Health Plan of Washington. I understand thirty (30) days written notice, to Kaiser Foundation Health Plan of Washington is required if I change banks and/or accounts.

Authorization signature:_____ Date: _____

Printed name:_____ Title:_____

Please note:
- Processing time for ACH is approximately thirty (30) days from receipt of completed form.
- Dates of deposit may vary due to individual financial institution data processing times.

For inquires call Member Services toll-free at **1-877-693-2269** or email **kpwa.apachconfirmation@kp.org**

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