

Kaiser Foundation Health Plan, Inc. Electronic Commerce Department Parsons East, 4th Floor 75 N. Fair Oaks Avenue Pasadena, CA 91103

Instructions:

Title of Authorized Signer:

Date:

 $Application \ must \ be \ \underline{completely} \ filled \ out \ (with \ the \ exception \ of \ one \ optional). \ Please \ email \ completed \ application \ to \ KP-AP-ACH@kp.org\ .$

Company Information						
Name:				Federal Ta	x ID:	
Address:						
City:			State: Zip Code:			
Accounts Receivable C	ontact Name:		Email:			
Phone #:			Fax #:			
(Optional)						
EDI/EFT Contact Name	::		Email:			
Phone #:			Fax #:			
and agree to work wire Financial Institute Info Bank Name:	th Kaiser to recover any payr	ment(s) made to	our account	t in error.		
Address:						
City:	State:			Zip Code:	:	
Bank Contact:						
Phone #: Fax			x #:			
ADA T '1 D 1' "						
ABA Transit Routing #: Bank Account:						
Account Type:	 Checking	Savir	inc.			
Account Type.	CHECKING	Savii	183			
ACH Payment Format:						
CTX (EDI X12 / 820, Electronic remit translation by bank)			CCD + Direct Deposit (Standard deposit without remittance)			
Email Remittance: (pro	vide single group email box)					
Email:						
hereby authorize Kaise	e information is true and cor er Permanente to electronic Kaiser Permanente, Accounts	ally deposit pay	ments to th	e designate	ed bank account. This a	authority
Printed Name of Aut	-					
Signature of Authoriz	zed Signer (handwritten signatu	re required):				