MEDI-CAL FOR FAMILIES

Electronic Funds Transfer Form

1. Applicant information

First Name:	Last name:
Family Member Number:	Monthly premium amount:

2. Bank information

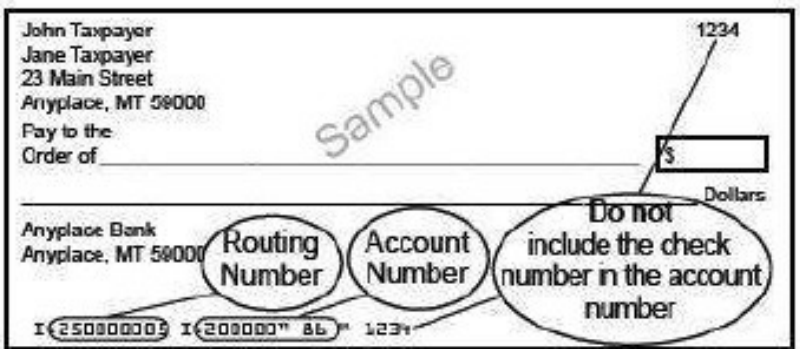
Bank Account Holder's First Name:	Bank Account Holder's Last Name:
Name of Bank:	Address of Bank Branch:
City:	State, Zip Code:

Account type: (Please check one)

☐ **Checking** Bank Transit Routing number | | | | | | | | | |

☐ **Savings** Account number | | | | | | | | | | | | | | |

See Sample for Routing & Account Numbers ⇨



3. Signature

I give permission to Medi-Cal For Families Program to begin withdrawing funds each month out of the account described above, in the amount of the monthly premium.

_____ _____

Signature of Bank Account Holder Date

_____

Printed Name of Bank Account Holder

NOTE: This permission to withdraw funds will remain in effect until Medi-Cal for Families receives written notice from the applicant to discontinue the monthly electronic funds transfer (EFT). In order to allow enough time to process your EFT form, **you will need to pay your premiums in another way until the EFT starts. The EFT will start approximately 6 to 8 weeks after you sign up.** If the applicant becomes no longer eligible for Medi-Cal For Families, the EFT will end.

Please complete this entire form. Enclose your current month's payment or savings deposit slip.

Mail to: Medi-Cal For Families
Premium Payment Section
PO Box 7187 Pasadena, CA 91109-7187

Questions? Call 1-800-880-5305, Monday to Friday, 8 a.m. to 7 p.m., or, on Saturday, 8 a.m. to 12 p.m. The call is free.