



ELECTRONIC PAYMENT AUTHORIZATION
Electronic Funds Transfer; Recurring Credit Card Payment
TRICARE Prime



You may choose to pay monthly TRICARE Prime enrollment fees by Electronic Funds Transfer from a specified checking or savings account **OR** by a Recurring Credit/Debit Card payment with a Visa® or MasterCard® logo. **(Note: Three-month's enrollment fee plus any past due amount MUST be submitted by check, money order or credit card with this authorization form.)**

Sponsor Name _____ Sponsor SSN/ID _____
 (Last, First, MI)

E-mail Address _____

Prime Monthly Enrollment Fee (Select One): Family \$38.34 Individual \$19.17

Action you wish TriWest to Take:

New Request Change to Existing Authorization Cancel Existing Authorization

Choose the EFT or Recurring Credit/Debit Card payment option and complete the appropriate section below.

Electronic Funds Transfer (EFT)

Account Holder's Name _____ Phone Number _____
 (Last, First, MI)

Account Holder Address _____
 Street City State ZIP

Bank Name _____ Bank Phone Number _____

Bank Address _____
 Street City State ZIP

ABA Routing Number (9 digits) _____ Account Type: Checking Savings

Bank Account Number _____

Return this form with a voided check (checking account) or deposit slip (savings account) and initial three-month payment including all past due amounts.

Recurring Credit/Debit Card Payment (Visa® or MasterCard®)

Cardholder Name _____ Cardholder Phone Number _____
 (Last, First, MI)

Cardholder Billing Address _____
 Street City State ZIP

Card Number _____ Exp Date _____ Type: Visa® MasterCard®

Cardholder Signature _____ Name as it appears on card _____

_____ Initial here to use the credit card information indicated above to make your three-month payment (\$115.00 family; \$57.50 individual) plus any past due amount.

I/We hereby authorize TriWest Healthcare Alliance Corp. on the 1st business day of each month to charge the above credit/debit card or initiate a debit entry to my/our checking or savings account from the financial institution indicated above. I/We understand that in the event the original transaction is rejected due to insufficient funds, a \$20.00 service charge will be directly billed to me/us, in addition to the enrollment fee owed for that month. I authorize TriWest Healthcare Alliance Corp. to convert my/our account to a quarterly payment option and to bill me/us for any past due amounts should my/our credit card be declined or my/our transaction be rejected due to insufficient funds. I/We also authorize TriWest to adjust my/our monthly enrollment fee at a future date should my/our enrollment status change. This authorization is to remain in full force and effect until TriWest Healthcare Alliance Corp. has received written notification from me (or either of us) of its termination in such time and manner as to afford TriWest Healthcare Alliance Corp. a reasonable opportunity to act on it. If I/we disenroll from the West Region, it is my responsibility to notify TriWest Healthcare Alliance Corp. to discontinue the Electronic Funds Transfer or Recurring Credit/Debit Card Payment.

 Signature Date

 Signature (if joint account) Date

Please submit this completed form **and** your three month payment (\$115.00 family; \$57.50 individual) plus any past due amount to:
 TriWest Healthcare Alliance; P.O. Box 43590; Phoenix, AZ 85080-3590

Privacy Act Statement – This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.” Violations may be punishable by fines, imprisonment, or both.