ELECTRONIC PAYMENT AUTHORIZATION
Electronic Funds Transfer; Recurring Credit Card Payment
TRICARE Reserve Select (TRS)

You may choose to pay monthly TRS premium payments 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.

TRS Member Name: _____ Member ID: __ __ __ - __ __ - __ __ __ __

Address: _____
Street City State ZIP

E-Mail Address: _____ Phone Number: _____

TRS Monthly Premium (Select One): ☐ TRS Member and Family ☐ TRS Member Only

Action you wish TriWest to Take:
☐ New Request ☐ Change to Existing Authorization ☐ Cancellation of Existing Authorization

Choose EFT or Recurring Credit/Debit Card Payment Option and complete the one corresponding section (EFT or Recurring) only.

☐ Electronic Funds Transfer (EFT)

Account Holder's Name: _____ Bank Name: _____

Bank Address: _____
Street City State ZIP

ABA Routing Number (9 digits): _____ Bank Phone Number: _____

Bank Account Number: _____ Account Type: ☐ Checking ☐ Savings

**Return this form with a voided check (checking account) or deposit slip (savings account).

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

Cardholder Name: _____

Cardholder Billing Address: _____
Street City State ZIP

Credit Card Number: _____ Expiration Date: _____

Signature of Cardholder: _____

I/We hereby authorize TriWest Healthcare Alliance 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 premiums may change on Jan. 1 each year, and I/we authorize TriWest Healthcare Alliance to charge/debit my/our account accordingly. I/We will be notified by TriWest Healthcare Alliance no later than 30 days prior to a change in premium amount. I/We understand that in the event that 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 premium owed for that month.

This authorization is to remain in full force and effect until TriWest Healthcare Alliance has received written notification from me (or either of us) of its termination in such time and in such manner as to afford TriWest Healthcare Alliance a reasonable opportunity to act on it. If I/we disenroll from the West Region, it is my responsibility to notify TriWest Healthcare Alliance to discontinue the Electronic Funds Transfer (EFT) or Recurring Credit/Debit Card Payment.

_____ _____
Signature Date Signature (if joint account) Date

Please submit to TriWest Healthcare Alliance; P.O. Box 42048 Phoenix, AZ 85080-2048.