



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 SSN/ID _____

Street Address: _____

City: _____ State: _____ ZIP: _____

E-mail Address: _____ Phone: (____) _____

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

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 that section below.

Electronic Funds Transfer (EFT)

Account Holder's Name: _____

Bank Name: _____ Bank Phone: (____) _____

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 (for a checking account) or deposit slip (for a savings account).**

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

Cardholder Name: _____ Phone: (____) _____

Cardholder Billing Address: _____

Street City State ZIP

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

Cardholder Signature: _____

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 **in the amount of \$180.17 family**_____/ **\$47.51 single**_____(**check one, effective for coverage beginning on or after 1/1/2009**) 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 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 manner as to afford TriWest Healthcare Alliance a reasonable opportunity to act on it. If I/we disenroll from the TRICARE West Region, it is my/our responsibility to notify TriWest Healthcare Alliance 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** check or deposit slip (if using EFT):

TriWest Healthcare Alliance
 P.O. Box 42048
 Phoenix, AZ 85080-2048

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.