ELECTRONIC PAYMENT AUTHORIZATION

TRICARE Prime Enrollment Fee

Electronic Funds Transfer

Make your enrollment fee payments online through your secure **www.triwest.com** account.

Sponsor Name _____ Sponsor SSN/Acct #_____

☐ **New** Authorization ☐ **Change** Existing Authorization ☐ **Cancel** Existing Authorization

When establishing an automatic payment, **you must pay a one-time quarterly payment** ($115.00 for family enrollment or $57.50 for individual enrollment) while TriWest sets up your automatic payment option.

You must choose **one initial payment** option and **one automatic fee payment** option below:

Choose **one initial payment** option	
Initial Quarterly Check/Money Order Payment	**Initial Quarterly** Credit/Debit Card Payment
☐ Family ($115.00)	☐ Family ($115.00)
☐ Individual ($57.50)	☐ Individual ($57.50)
Attach Payment	***Fill out Section B***

Choose **one automatic fee payment** option	
Automatic Monthly Allotment Payment	**Automatic Monthly** Electronic Funds Transfer
Please fill out the Allotment Authorization Form (*www.triwest.com/epay)* and include the initial payment information.	☐ Family ($38.34)
	☐ Individual ($19.17)
	Fill out Section A

Section A: Automatic Fee Payment by 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 (attach voided check)

Bank Account Number: _____ ☐ Savings (attach deposit slip)

Section B: Initial Payment by Credit/Debit Card (Visa®, MasterCard®, Discover®)

Cardholder Name: _____ Phone: (____)_____

Cardholder Billing Address: _____

Street City State ZIP

Card Number _____ Exp Date _____

Cardholder Signature: _____ Type: ☐ Visa® ☐ MasterCard® ☐ Discover®

I/We hereby authorize TriWest Healthcare Alliance on the 1st business day of each billing cycle to 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 billing cycle. 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 the credit/debit card be declined or the 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 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 automatic fee payment option.

_____ _____

Signature Date Signature (if joint account) Date

Please submit this signed and completed form along with initial payment 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.