Electronic Payment Authorization Form

PLEASE RETURN BY MARCH 10th

Please type or print all entries.

Coverage: ☐ **Prime** ☐ **TRS** (TRICARE Reserve Select) ☐ **TRR** (TRICARE Retired Reserve) ☐ **TYA** (TRICARE Young Adult)

APPLICANT Name: Last	First	M.I.	**SPONSOR** SSN or DBN

Home Address: Street	Apt. No.	City	State	ZIP Code

Step 1: Please select the method of payment option you wish to start below.

☐ **Electronic Funds Transfer (EFT):** Please begin automatic withdrawal of my monthly premiums/enrollment fees payable to UnitedHealthcare Military & Veterans by means of EFT from my financial institution.

Please check one: ☐ Checking ☐ Savings

_____
Name of Financial Institution

_____	_____	_____
Name of Account Holder	9 Digit Bank or ABA Routing Number	Account Number

☐ **Recurring Credit Card (RCC):** Please begin automatic withdrawal of my monthly premiums/enrollment fees payable to UnitedHealthcare Military & Veterans by means of RCC from my financial institution.

Please check one: ☐ Visa ☐ MasterCard ☐ Discover *charges will appear as "UnitedHealthcare" on your credit card statement*

_____	____-____-____-____	____/____
Name of Card Holder	16 Digit Credit Card Number	Expiration Date (MM/YYYY)

Step 2: Prepayment of 2 months premiums/enrollment fees due with the submission of your request.

Note: If effective date of the enrollment was not the first of the month, prorated premiums may also apply.

☐ **Pay by Check:** I wish to pay the prepayment of two-month's premiums/enrollment fees by enclosed check payable to UnitedHealthcare.

☐ **Pay by Credit Card:** I wish to pay the prepayment of two-month's premiums/enrollment fees by credit card indicated below.

Check box: ☐ Visa ☐ MasterCard ☐ Discover ☐ If credit card is the same as RCC, check this box and skip to Step 3

_____	____-____-____-____	____/____
Name of Card Holder	16 Digit Credit Card Number	Expiration Date (MM/YYYY)

Step 3: Authorize this request with your signature and return by mail or fax.

My signature authorizes UnitedHealthcare Military & Veterans to begin withdrawal of my premium/enrollment fee payments as determined by TRICARE *(rates subject to change with 30-day notice – see www.tricare.mil/costs)* on the first business day of each month using the payment option selected in Step 1 and the one-time prepayment of two-month's premium/enrollment fee payments(1) if selected in Step 2. This authorization will remain in full force unless cancelled by me in writing, UnitedHealthcare or my financial institution. I understand a $20 administrative fee will be assessed for any payments returned due to insufficient or unavailable funds.

Authorized Signature (*Required*): _____ **Date:** _____

Mail this form to: UnitedHealthcare Military & Veterans
TRICARE West Region Enrollment Department
P.O. Box 105492
Atlanta, GA 30348-5492

or Fax this form to: 1-877-890-7297

THANK YOU FOR YOUR SERVICE!

Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as "official use only."

TRICARE West Region Customer Service: 1-877-988-9378(WEST) - www.uhcmilitarywest.com