



Electronic Payment Authorization Form

Please type or print all entries.

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|--|----------|-------|-------|---------------------|
| Coverage: <input type="checkbox"/> Prime <input type="checkbox"/> TRS (TRICARE Reserve Select) <input type="checkbox"/> TRR (TRICARE Retired Reserve) <input type="checkbox"/> TYA (TRICARE Young Adult) | | | | |
| Sponsor Name: Last | | First | M.I. | Sponsor SSN or DBN |
| TYA Beneficiary Name: Last | | First | M.I. | TYA Beneficiary SSN |
| Home Address: Street | Apt. No. | City | State | ZIP Code |

Step 1: Choose the action you wish us to take.

START First Time Request (Complete Steps 2, 3 & 4 Below)
 CHANGE Request to Existing (Complete Steps 2 & 4 Only)
 STOP Request to Existing (Complete Step 4 only)

Step 2: Select payment option to start or change and provide information requested.

Electronic Funds Transfer (EFT): Please start or change the 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 start or change the 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 3: Prepayment of 2 months premiums/enrollment fees due with the submission of your **START** 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 4

_____ / _____

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

Step 4: Authorize this request with your signature and return by mail or fax.

My signature authorizes UnitedHealthcare Military & Veterans to START, CHANGE or STOP my automated payments as indicated in STEP 1. Rates, as determined by TRICARE (*rates subject to change with 30-day notice – see www.tricare.mil/costs*), will be withdrawn on the first business day of each month using the payment option selected in Step 2 and the one-time prepayment of two-month's premium/enrollment fee payments⁽¹⁾ if selected in Step 3. 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 statement serves to inform you of the purpose for collecting personal information required by the UnitedHealthcare Military & Veterans Information System and how it will be used.

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| AUTHORITY: | 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended. |
| PURPOSE: | To collect information from you in order to manage your TRICARE enrollment, provide your benefits, and/or pay for those services. |
| ROUTINE USES: | <p>Your records may be disclosed to investigate waste, fraud, abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNS/blanket_routine_uses.html and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).</p> <p>Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.</p> |
| DISCLOSURE: | Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process your request. |