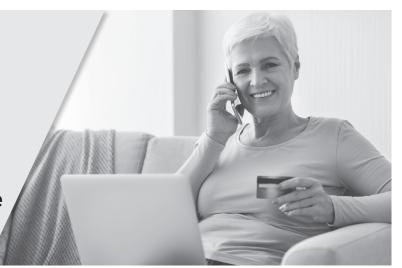


Simplify your payments, save money, and find digital resources at your fingertips!

Create an account in the Secure Enrollee Portal (SEP) today!



We're here for you during these challenging times. We encourage you to use the Secure Enrollee Portal (SEP) to access all of your information online. You can access your invoice online, as well as digital ID cards, coverage documents and the resources you need to help you stay safe and healthy.

Set up Online Invoices and Automatic Payments

Simplify your invoices and payments. No need to go to the post office or worry about sending in your payment. Make it easy to pay your monthly bill and save money on postage, too! Switch to electronic invoices and sign up for one of these automatic monthly payment options:

- *Go Paperless* Simply log in to your account, click "Invoices" then click on the button that says, "Go Paperless!" to get your monthly invoice online only.
- Automatic monthly ACH* withdrawal from your checking or savings account. Simply complete the form on the back of this flyer and return it to HealthTrust.
- Automatic monthly payment from your debit card or credit card. Please call HealthTrust Enrollee Services at 800.527.5001 to be enrolled.

Payment for your medical and/or dental plan coverage is **due to HealthTrust no later than the 10th of the month**. In order to ensure your coverage continues smoothly, please ensure that your payment is received by the 10th of each month.

If you have questions regarding this notice or HealthTrust's payment policy for Retiree medical and/or dental coverage invoices, please call Enrollee Services at **800.527.5001**.

Thank you.

*Automated Clearing House 4/20



RETIREE ACH AUTHORIZATION FORM

RETIREE INFORMATION:

Last Name	First Name			MI
Street Address	Town/City		State	Zip
()				
Phone #	Email Address			
DEPENDENT INFORMATION (IE ADDI ICADI EV			
(Provide First Name and Last Nam				
Spouse:		Dependent Chil	d:	
Dependent Child:		Dependent Child:		
BANK ROUTING NUMBER	BANK ACCOUNT NUMBER ACC		ACCOUNT	ТҮРЕ
BANK INFORMATION:				
			☐ Checking	☐ Savings
Nine Digit Number	Your Account Num	ber		
I hereby authorize HealthTrust, Inc. ("He medical and/or dental contributions. Plea each month, or the next business day ther the ACH withdrawal amount and agree to plan coverage changes including retro adjude to insufficient funds will be assessed received written notification from me of i	ase withdraw from the bank a reafter. I understand that cha that HealthTrust may increas justments, outstanding balan a \$20.00 "Returned Check"	account indicated abounges in coverage and e or decrease the amoustices, and/or renewal refee. This authorization	ove the Total Amount loor rates may result in bunt as necessary due to tate changes. Any ACH on will remain in force	Oue on the 10th day of an increase or decrease of o: medical and/or dental debit transaction denied
AGREED TO:				
Signature:			Date:	
Your first ACH withdrawal will completed form. Please note: You			•	_
Return completed form to: Hea	althTrust, P.O. Box 617 to 603-226-2988, Atter			
For Internal Use Only:	Custo	Effective Date omer ID# omer ID#	An	nount