



## COBRA COVERAGE ACH AUTHORIZATION FORM

### ENROLLEE INFORMATION:

Last Name	First Name	MI
Street Address	Town/City	State
( )		Zip
Phone #	Email Address	

### BANK INFORMATION:

BANK ROUTING NUMBER	BANK ACCOUNT NUMBER	ACCOUNT TYPE
_____	_____	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Nine Digit Number	Your Account Number	

I hereby authorize HealthTrust, Inc. ("HealthTrust") to process Automated Clearing House (ACH) transactions for payment of monthly medical and/or dental contributions. Please withdraw from the bank account indicated above **the Total Amount Due on the 25<sup>th</sup> of the month**. I understand that changes in coverage and/or rates may result in an increase or decrease of the ACH withdrawal amount and agree that HealthTrust may increase or decrease the amount as necessary due to: medical and/or dental plan coverage changes including retroactive adjustments, outstanding balances, and/or renewal rate changes. This authorization will remain in force until HealthTrust has received written notification from me of its termination or coverage through HealthTrust has ended.

### **AGREED TO:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Your ACH withdrawal will occur on the 25<sup>th</sup> of the month.**

**Return completed form to:** HealthTrust, P.O. Box 617, Concord, NH 03302-0617, or  
fax to 603.226.2988, Attention: Finance Dept., or  
log in to your Secure Enrollee Portal account and click Message Center.

<b>For Internal Use Only:</b>	ACH Effective Date _____
OS _____ GP _____	Customer ID# _____ Amount _____
CTZN _____	Customer ID# _____ Amount _____