HealthTrust

RETIREE ACH AUTHORIZATION FORM

RETIREE INFORMATION:

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

SPOUSE INFORMATION (IF APPLICABLE):

(Please provide first and last name of spouse if you are invoiced separately and would like this ACH applied to both accounts.)

Spouse:

BANK INFORMATION:

BANK ROUTING NUMBER	BANK ACCOUNT NUMBER	ACCOUNT TYPE
_____	_____	☐ Checking ☐ 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 1st 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 1st 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.

For Internal Use Only: ACH Effective Date _____

OS _____ GP _____ Customer ID# _____ Amount _____

CTZN _____ Customer ID# _____ Amount _____

Revised 01/25