



INSTRUCTIONS FOR BANK DRAFT AUTHORIZATION FORM

The following must be completed to authorize your automatic bank draft after you pay the initial paper invoice. If you are changing bank account information, this form must be received in our office ten (10) days prior to the next scheduled draft date.

1. **Signature of Applicant/Member (Required)** – Member (coverage owner) must sign and date in agreement to the terms and conditions as set forth in the Bank Draft Authorization form. The form must be signed by parent or legal guardian if member is under age 18.
2. **Signature of Payor (Required) and Print Payor Name (Required)** – Payor (owner/signatory of account) must sign and print name.
3. **Applicant/Member Name (Print)** – Member must print name.
4. **Identification Number** – Member’s TRH identification number must be included.
5. Check **“Health,” “Dental,” and/or “Prescription”** box(es) that apply.
6. Check **“Bank Change”** box and write in effective date of change.
7. If personal account, check **“Personal Account”** box and check **“Checking”** or **“Savings”** account. If business account, check **“Business Account”** box. Member (subscriber) must be the owner of the business or one (1) of two (2) employees. Please check appropriate box. If member is not owner of business or an employee, a “Not An Employee” form must be submitted.
8. Attach voided check to bottom of form if bank account is checking. **Deposit slips will not be accepted.** If savings account, this form must be taken to your financial institution for completion, including signature and telephone number of authorized representative.
9. Mail completed form to **TRH Health Plans, P.O. Box 313, Columbia, TN 38402-0313, or you may fax to (931) 560-4278, Attention: Billing Department.**
10. Verify receipt of mailed or faxed form by calling (931) 388-7872 or toll free (877) 874-8323 and request to speak to a Billing Department representative.

Please note: *Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.*



BANK DRAFT AUTHORIZATION FORM

Health **Dental** **Prescription** **(Check all that apply)**

I hereby authorize TRH Health Plans to initiate debit entries from the account indicated below for the monthly payment of health, dental, or prescription coverage. The depository named below is authorized to debit the same to my account. I acknowledge I am authorized to sign this agreement on behalf of all covered individuals and signatories to the account. I further understand I have the right to revoke this authorization by notifying TRH Health Plans in writing at least ten (10) days prior to the time payment is due and my account is charged in order to give TRH Health Plans a reasonable opportunity to act upon it. I further agree that should a debit be dishonored, whether with or without cause and whether intentionally or inadvertently, TRH Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Print Applicant/Member Name (Required)

Print Payor Name (Required)

Signature of Applicant/Member (Required)
(Must be signed by parent/guardian of minor applicant)

Signature of Payor (Required)

Date

County

Subgroup

TRH ID Number-Health

TRH ID Number-Dental

TRH ID Number-Prescription

- Quarterly to Bank Draft _____
- New Application (effective date)
- Transfer
- Bank Change _____
(effective date)

- PERSONAL ACCOUNT** - Checking Savings
- BUSINESS ACCOUNT**
- 1. Subscriber is owner of business Yes No
- 2. If no, Subscriber is an active employee Yes No
- 3. If employee, Subscriber is one (1) of two (2) full-time employees Yes No

PLEASE READ CAREFULLY

For Checking Accounts: Attach voided check here (No Deposit Slips)
For Savings Accounts : Take form to Financial Institution for completion (No Deposit Slips)

Name and Address of Financial Institution

Routing Number

Account Number

Signature, Authorized Representative of Financial Institution

Telephone Number

Cancellation- The subscriber may cancel this coverage for any reason by giving ten (10) days written notice to TRH Health Plans. Coverage will remain in effect until the paid-to date. Please see your contract for specific information regarding cancellations and cancellations due to death of member.