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):

(Provide First Name and Last Name)

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 10th of the month through December 10, 2024 and on the 1st of the month, starting January 1, 2025.** 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 10th of the month through December 10, 2024 and on the 1st of the month, starting January 1, 2025.

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 _____