TRH HEALTH PLANS
Live better. Save more. Farm Bureau

INSTRUCTIONS FOR BANK DRAFT AUTHORIZATION

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/Subscriber (Required)*** – Subscriber must sign and date that he/she agrees to the terms and conditions as set forth in the Bank Draft Authorization. The form must be signed by parent or legal guardian if member is under age 19.

2. ***Signature of Payor (Required) and Print Payor Name (Required)*** – Payor (owner/signatory of account) must sign and print name.

3. ***Applicant/Subscriber Name (Print)*** – Subscriber must print name.

4. ***Identification Number*** – Subscriber'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. Subscriber must be the owner of the business or one (1) of two (2) employees. Please check appropriate box. If Subscriber 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***.

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BANK DRAFT AUTHORIZATION

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

I hereby authorize TRH Health Plans ("TRH") 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 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 in writing at least ten (10) days prior to the time payment is due. I further agree that should a debit be dishonored, whether with or without cause and whether intentionally or inadvertently, TRH shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

_____ _____

Print Applicant/Subscriber Name (Required) **Print Payor Name (Required)**

_____ _____

Signature of Applicant/Subscriber (Required) **Signature of Payor (Required)**

(Must be signed by parent, step-parent or legal guardian of minor applicant)

_____ _____ _____

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 <u>Checking</u> Accounts: Attach voided check here (No Deposit Slips)
For <u>Savings</u> 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. 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 Subscriber.