Simplify your payments, save money, and find digital resources at your fingertips!

Create an account in the Secure Enrollee Portal (SEP) today!

We're here for you during these challenging times. We encourage you to use the Secure Enrollee Portal (SEP) to access all of your information online. You can access your invoice online, as well as digital ID cards, coverage documents and the resources you need to help you stay safe and healthy.

Set up Online Invoices and Automatic Payments

Simplify your invoices and payments. No need to go to the post office or worry about sending in your payment. Make it easy to pay your monthly bill and save money on postage, too! Switch to electronic invoices and sign up for one of these automatic monthly payment options:

- ***Go Paperless -*** Simply log in to your account, click "Invoices" then click on the button that says, "Go Paperless!" to get your monthly invoice online only.
- **Automatic monthly ACH* withdrawal from your checking or savings account.** Simply complete the form on the back of this flyer and return it to HealthTrust.
- **Automatic monthly payment from your debit card or credit card.** Please call HealthTrust Enrollee Services at **800.527.5001** to be enrolled.

Payment for your medical and/or dental plan coverage is **due to HealthTrust no later than the 10th of the month**. In order to ensure your coverage continues smoothly, please ensure that your payment is received by the 10th of each month.

If you have questions regarding this notice or HealthTrust's payment policy for Retiree medical and/or dental coverage invoices, please call Enrollee Services at **800.527.5001**.

Thank you.

**Automated Clearing House*

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RETIREE ACH AUTHORIZATION FORM

RETIREE INFORMATION:

Last Name ______ First Name ______ MI ______

Street Address ______ Town/City ______ State ______ Zip ______

Phone # ______ Email Address ______

DEPENDENT INFORMATION (IF APPLICABLE):

(Provide First Name and Last Name)

Spouse:	**Dependent Child:**
Dependent Child:	**Dependent Child:**

BANK INFORMATION:

BANK ROUTING NUMBER ______ Nine Digit Number

BANK ACCOUNT NUMBER ______ Your Account Number

ACCOUNT TYPE ❏ Checking ❏ Savings

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 day of each month, or the next business day thereafter. 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 retro adjustments, outstanding balances, and/or renewal rate changes. Any ACH debit transaction denied due to insufficient funds will be assessed a $20.00 "Returned Check" fee. 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 first ACH withdrawal will occur on the 10th of the month following HealthTrust's receipt of this completed form. Please note: You will continue to receive an invoice each month for your records.

Return completed form to: **HealthTrust,** P.O. Box 617, Concord, NH 03302-0617, or
Fax to 603-226-2988, Attention: Finance Dept.

For Internal Use Only:	ACH Effective Date ______ Customer ID# ______ Amount ______ Customer ID# ______ Amount ______

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