

Personal Information (Please Print)

Member Name:			Member ID Number:		
Street Address:					
City/State:				Zip Code:	
Telephone:					

Financial Institution Information

Financial Institution Name:					
Account Holder's Name:			Account Holder's Telephone Number:		
Nine-Digit ABA Routing Number:					
Account Number:			<input type="checkbox"/> Checking <input type="checkbox"/> Savings		

Please attach a check marked "VOID," or a savings account deposit slip with the account number for the checking or savings account from which you want money withdrawn for your Tufts Health Plan Medicare Preferred HMO monthly plan premium.

Eligibility

In order to be eligible for the EFT program, you must be current with your Tufts Medicare Preferred HMO Plan premium payments. **If you currently have an outstanding balance, please include a check or money order with your EFT Authorization Form.** Please mail the completed form along with a voided check or savings account deposit slip, and, if applicable, payment for any outstanding balance, to the Tufts Medicare Preferred Enrollment Department at the address listed below.

Checking/Savings Account Authorization Agreement

I hereby authorize the monthly debit to the account referenced above for the Tufts Medicare Preferred HMO monthly plan premium of the above listed member.

I understand that I should continue to pay my monthly premium until I receive written confirmation from Tufts Medicare Preferred confirming the activation and start date of electronic fund transfers from my account. I understand that my account must have the full dollar amount due in available funds on a monthly basis. I understand that my bank may charge a fee if there are insufficient or uncollected funds in my account. I understand that Tufts Medicare Preferred retains the right to revoke or change my participation in the EFT program at any time. I also understand that I have the right to stop automatic payments by notifying Tufts Medicare Preferred by phone or in writing before the 8th of the month in order to discontinue for the following month.

➔ **Signature:** _____ **Date:** _____

Completed applications may be mailed in the enclosed envelope provided to:
 Tufts Medicare Preferred, 705 Mount Auburn Street, Mail Stop 69, Watertown MA 02472,
 Attn: EFT Enrollment

Tufts Medicare Preferred will not disclose your banking information to any third parties unless you authorize us to do so.