

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

TUFTS  Health Plan
Medicare Preferred

About EFT

When you sign up for EFT, your monthly premium payment is automatically deducted from your checking or savings account each month and transferred to Tufts Health Plan Medicare Preferred.

How To Sign Up

Complete this form and mail it to:

Tufts Health Plan Medicare Preferred
Attention: EFT Enrollment
705 Mount Auburn Street, Mail Stop 69
Watertown MA 02472

We will contact you by mail when your application has been approved. Please continue to pay your monthly premium until we notify you of your enrollment in the EFT program.

Member Information (Please Print)

Member Name: _____

Member ID #: _____ Telephone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Account Information

Bank or Financial Institution Name: _____ Account Holder's Name: _____

Account Holder's Telephone Number: _____ Nine-Digit ABA Routing Number: _____
(This number can be found on the bottom left corner of your check. If using a savings account, this number can be obtained from your bank.)

Account Number: _____ Checking Savings

Please attach a check marked "VOID" with the checking account number you want your Tufts Health Plan Medicare Preferred monthly plan premium withdrawn from.

Your signature needed on back ⇨

Eligibility

In order to be eligible for the EFT program, you must be current with your Tufts Health Plan Medicare Preferred premium payments. **If you currently have an outstanding balance, please include a check or money order for your outstanding balance amount with this form.**

Checking/Savings Account Authorization Agreement

I hereby authorize the monthly debit to the account referenced above. I understand that I should continue to pay my monthly premium until I receive written confirmation from Tufts Health Plan Medicare Preferred confirming the activation and start date of electronic funds transfer 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 Health Plan 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 Health Plan Medicare Preferred by phone or in writing before the 8th of the month in order to discontinue for the following month.

⇒ **Signature:** _____ **Date:** _____

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