Enrollment Fee Allotment Authorization Letter

Please type or print all entries.

Name: Last	First	M.I.	Sponsor SSN
Home Address: Street	Apt. No.	City	State / Zip Code

Indicate below the action you wish to take for the allotment process.

Please mark one of the three boxes and complete the requested information.

☐ Please **Start** a monthly allotment to TriWest from my retirement pay for TRICARE Prime enrollment fees for the TRICARE West Region in the amount of: $_____ (Single $19.17 or Family $38.34).

I have enclosed a payment (personal check, cashier's check, traveler's check, money order or credit card, e.g., Visa/Master card) for the 3-month payment ($57.50 individual or $115.00 family) of TRICARE Prime enrollment fees payable to TriWest. I understand that this payment is waived when transferring from another region and an allotment has already been set up in that region.

☐ Please **Change** my existing monthly allotment to TriWest from $ _____ to $ _____ effective (MM/YY) _____/_____. Single to Family ($19.17 to $38.34)
Family to Single ($38.34 to 19.17)

☐ Please **Stop** my existing allotment to TriWest effective (MM/YY) _____/_____.

I hereby authorize the above action (start, change or stop) be taken by TriWest from my military retirement pay. I understand that this authorization will remain in effect until I request that it be changed or stopped. However, as a courtesy to me, I also hereby authorize TriWest to automatically stop this allotment at a future date if I become disenrolled from the TRICARE West Region for any reason, including transferring my enrollment to a different TRICARE region.

Sponsor Signature (Required):_____ Date: _____

TriWest will attempt to start the allotment from your military retirement pay by the next payment due date. You will be notified by TriWest to make alternative payment arrangements if the allotment from your retirement pay could not be started by this date. Allotments are only authorized from military retirement pay received from either; DFAS, Coast Guard or Public Health. Other payments received such as VA benefits, Survivor Benefits or Combat Related Compensation are not eligible.

If completing this form as part of your Enrollment Form, please include with the Enrollment Form.

Please complete, sign, and mail this form and payment to:

TriWest Healthcare Alliance
P.O. Box 43590
Phoenix, AZ 85050-3590