

For Office Use Only: ID #: Draft Effective Date: Submitted By:

Commitment To Pay Premiums

I understand, as agreed in the Evidence of Coverage, that all premiums are due in the office of the Scott & White Health Plan (SWHP) on or before the first day of each month.

FOR INITIAL PAYMENT ONLY: Fax to: 254-298-3567, Attn: Health Plus Mail to: Scott & White Health Plan, Attn: Health Plus, 2401 South 31st Street, Temple, TX 76508

ONGOING PAYMENT OPTIONS: Mail to: Scott & White Health Plan, Attn: Accounts Receivable, 2401 South 31st Street, Temple, TX 76508

- Monthly Coupon Payment (Pay by check or money order) E-Pay (Ongoing payments must be made monthly by the member on our Website at www.swhp.org or call 1-877-255-1400. Bank Draft (Bank drafts occur between the 4th and 9th of the month. Fill in the financial institution information.)

For Bank Draft - please read the following and fill in the financial institution information below:

I hereby authorize SWHP to initiate debit entry to my monthly premium from my financial institution which is indicated below. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with the provisions of U.S. law.

Financial Institution Name: Routing Number: Account Number: Type of financial institution account: Checking Account Savings Account

If any ACH transaction does not clear my account on the first attempt, I will be notified and given a deadline to make the payment. Multiple returned payments can result in the loss of the eligibility to pay electronically or the termination of coverage.

Contract Holder Name (Printed) Contract Holder Signature Date Authorized Signature for Account (if different than Contract Holder) Date