

For Office Use Only: ID #: _____ Draft Effective Date: _____ Submitted By: _____
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Commitment To Pay Premiums Form

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.** The contract holder is responsible for remitting all premiums due under this Agreement to SWHP when due. I agree that these payments will be made by the first day of the month for coverage effective the first of the month. (SWHP **will not** accept a check or initiate a draft from an employer's account unless you are the sole proprietor of the business and the payment is for you and your immediate family's coverage only.)

INITIAL payment only: Fax: 254-298-3567, Attn: Individual & Family Plans (IFP)
Mail to: Scott & White Health Plan, Attn: IFP, MS-A4-126, 1206 West Campus Drive, Temple, TX 76502

Check or Money Order

I hereby authorize the Scott & White Health Plan to initiate entry to my credit card account indicated below:

MASTERCARD VISA DISCOVER AMERICAN EXPRESS

Credit Card Number: _____ - _____ - _____ - _____

Name on Card: _____ Expiration Date: _____/20_____

Card Billing Address (address where you receive your credit card statements):

Street Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

ONGOING payment options: Mail to: Scott & White Health Plan, Attn: Accounts Receivable, MS-A4-126, 1206 West Campus Drive, Temple, TX 76502

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**. Payments can be made using your checking or savings account, credit or debit card.)

Bank Draft (Please attach a "VOID" check. **Do not** use a deposit slip as some financial institutions use different routing numbers for deposits. SWHP cannot accept temporary checks. Bank drafts occur between the 4th and 9th of the month. Saving Account withdrawals require written confirmation from the financial institution showing the savings account and routing numbers. Complete the information below.)

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. This authorization is to remain in full force and effect until SWHP has received written notification from me of its termination in such time and in such manner as to afford SWHP and my financial institution a reasonable opportunity to act on it.

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. I understand that not paying my premium by the due date can result in termination of coverage.

Contract number: _____ **Phone number:** _____

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