Commitment to Pay Premiums (CPP) form

I understand, as agreed in the Evidence of Coverage, that all premiums are due in the office of the Health Plan on or before the first day of each month. The Contract Holder is responsible for remitting all premiums due under this Agreement to Health Plan 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.

FOR INITIAL PAYMENT ONLY:

☐ **Check or Money order.**

☐ **I hereby authorize the Health Plan to initiate entry to my credit card account indicated below.**

Financial Institution Name: _____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration date: ____/____/20____ Name on Card: _____

ONGOING PAYMENT OPTIONS:

☐ **Monthly Coupon Payment** (Pay by check or money order)

By choosing one of electronic payment methods below, I understand that I am eligible to receive a discount on my monthly premium; however, if I choose to no longer pay my premiums electronically, my account will be adjusted to reflect the non-discounted rate.

☐ **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** (Fill in the financial institution information)

(Please note: Bank drafts occur between the 4th and 9th of the month.)

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

I hereby authorize the Health Plan 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 the Health Plan has received written notification from me of its termination in such time and in such manner as to afford the Health Plan 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 Holder Name Printed | Contract Holder Signature | Date

_____ _____

Authorized Signature for Account (If different than Contract Holder) | Date

FOR OFFICE USE ONLY

Draft Effective Date _____ Contract ID Number _____

Submitted by_____