JOHNS HOPKINS
MEDICINE
US FAMILY HEALTH PLAN

AUTOMATIC PAYMENT FORM

AUTOMATIC CHECKING ACCOUNT WITHDRAWAL AUTHORIZATION

Please complete the section below and ATTACH A VOIDED CHECK if you would like to have your US Family Health Plan Enrollment Fee deducted from your checking account.

I, ______________________________, authorize Johns Hopkins Medical Services Corporation to withdraw my monthly enrollment fee from my checking account at the financial institution listed below. I understand that I am responsible for making certain that adequate funds are available in my account for withdrawal and will be liable for any charges incurred for insufficient funds. This authorization remains in effect unless I cancel in writing or it is voided by Johns Hopkins Medical Services Corporation.

Sponsor's Name ______________________________ Sponsor's DOB ______________
My Name ______________________________ My DOB ______________
My Email Address ______________________________
Financial Institution ______________________________
Address ______________________________
Routing Number ______________________________ Account Number ______________

To the best of my knowledge this information is correct.

______________________________ ______________________________
Signature Date

CREDIT CARD AUTHORIZATION

Please complete the section below if you would like to have your US Family Health Plan Enrollment Fee charged to your credit card. We accept MasterCard, Visa and Discover.

I, ______________________________, authorize Johns Hopkins Medical Services Corporation to charge my **(circle one)** **Monthly** or **Quarterly** enrollment fee to my credit card listed below. I understand that I am responsible for making certain that adequate credit is available and will be liable for any charges incurred for insufficient credit. This authorization remains in effect unless I cancel in writing or it is voided by Johns Hopkins Medical Services Corporation.

Sponsor's Name ______________________________ Sponsor's DOB ______________
My Name ______________________________ My DOB ______________
My Email Address ______________________________
☐ MasterCard ☐ Visa ☐ Discover Card
Card # ______________________________ Expiration Date ______________
To the best of my knowledge this information is correct.

______________________________ ______________________________
Signature Date

MAKE A COPY OF THIS FORM FOR YOUR RECORDS. If you change or close your account, please contact us. In the event that your payment does not clear, you will be notified and asked to reconcile as soon as possible so that your health care coverage will not be disrupted.

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