JOHNS HOPKINS MEDICINE
US FAMILY HEALTH PLAN

ENROLLMENT FEE ALLOTMENT AUTHORIZATION

Please type or print all entries.

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

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 Johns Hopkins Medical Services Corporation from my retirement pay for USFHP enrollment fees in the amount of: $ _____ (Single $24.75 or Family $49.50)

Please circle card type: Visa | Mastercard | Discover

Card Number _____ *Exp* ____/____ *Amount* ____.____ *Todays date* _____

☐ Please **Change** my existing monthly allotment to JHMSC from $ _____ to $ _____
My status changed as of (MM/YY) ____/____
Single to Family ($24.75 to $49.50)
Family to Single ($49.50 to $24.75)

☐ Please **Stop** my existing allotment to JHMSC so that my USFHP coverage is paid through the last day of (MM/YY) ____/____

I hereby authorize this allotment to be taken from my military retirement pay. I understand that it will remain in effect until I request that it be changed or stopped. However, as a courtesy to me, I also authorize JHMSC to automatically stop this allotment at a future date if I become disenrolled from the USFHP for any reason, including transferring my enrollment to a different USFHP/TRICARE® region.

Signature (Required): _____ Date: _____

JHMSC will attempt to start the allotment from your military retirement pay by the next payment due date. You will be notified by JHMSC to make alternative payment arrangements if the allotment from your retirement pay could not be started by this date.

If you have questions or comments, please call 888-717-8282

Mail this form with your Enrollment application if completing it as part of your new enrollment.

OR

If you're already a US Family Health Plan Member, mail this form and payment to:

Johns Hopkins Medical Services Corporation
PO Box 8689
Elkridge, MD 21075