JOHNS HOPKINS
HEALTH PLANS

AUTOMATIC PAYMENT FORM

The Defense Health Agency mandates that enrollment fees be paid by allotment from a retirement account. These automatic payment methods are only available to members with an approved exemption. Allotment waivers will be granted for these scenarios: 100% disability, no retirement account or not enough funds in a retirement account to cover enrollment fees.

Sponsor's Name _____ Sponsor's DOB_____

My Name (if different) _____ My DOB_____

My Email Address _____

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 Health Plans 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 Health Plans.

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, American Express and Discover.

I, _____, authorize Johns Hopkins Health Plans 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 Health Plans.

☐ Mastercard ☐ Visa ☐ American Express ☐ 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.