



JOHNS HOPKINS  
M E D I C I N E

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 \_\_\_\_\_  
Financial Institution \_\_\_\_\_  
Address \_\_\_\_\_  
Branch \_\_\_\_\_ 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 and Visa.

I, \_\_\_\_\_, authorize Johns Hopkins Medical Services Corporation to charge my 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 \_\_\_\_\_  
 MasterCard  Visa 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. Your statement will show the name Johns Hopkins Community Physicians, which is the designated provider for US Family Health Plan at Johns Hopkins.