Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

For Office Use Only:
Draft Effective Date: _____
Submitted By: _____
Contract ID Number: _____

Commitment to Pay Premiums

Authorization Agreement for Payments (Scott & White Health Plan Payments for Individual & Family Plans):

This form is to update Ongoing payment options. Scott & White Health Plan Individual & Family plans are pre-paid health insurance coverage, which means you pay your initial premium payment and subsequent payments for coverage prior to the month of coverage. Please select your premium payment option below by putting a "check mark" in the appropriate box and then completing the corresponding financial information. The payment option selected will be effective on the first of the month following receipt of this form.

For assistance completing this form or changing the method of your premium payments, contact SWHP Customer Service via email at swhp.org or by calling 1-800-321-7947, Monday – Friday, 8:00 AM – 5:00 PM. (Any change in the method of payment will be dependent on the time of month the request is made and the type of payment method requested.)

Policy Holder's Information Name (First & Last): _____
Policy Number (Required): _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Home Phone: _____ Other Phone: _____
Signature: _____ Date: _____

Select an ongoing payment option below and return this form before the end of the month.

Ongoing Premium Payment Option: (please select below)

☐ Cancel My Automatic Bank Draft *Effective the 1st of the following month. (I will pay my premiums directly)*
☐ Update Automatic Bank Draft *Complete banking information below*. Note: If you have multiple policies, each will draft separately.
☐ Paper Invoice *Pay monthly by check/money order. (Make payable to Scott & White Health Plan)*
☐ Pay Online *Payments are made online at swhp.org. This includes one-time or reoccurring payments.*

Automatic Bank Draft information: Occurs approximately between the 4th and 11th

☐ Checking Account ☐ Savings Account
Name of Financial Institution: _____
Account Number: _____ Routing Number: _____
Name on Account: _____
Authorized Signature for Account: _____ Date: _____

Important: If your initial payment by Credit/Debit Card is electronically declined, your policy will not be issued. If an ongoing ACH bank draft payment is electronically declined your policy will be terminated back to the first of the month in which the draft was declined. A new application will be required to obtain future coverage. ACH returns must be paid with certified funds (cashier's check or money order). Any amount not paid by your financial institution will be assessed a $30 fee.

Please return this completed form by mail or fax to:
Attn: Accounts Receivable/ Membership

Scott & White Health Plan
MS-A4-126
1206 West Campus Drive
Temple TX, 76502

OR

Fax Number : 254-298-3199