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

Commitment to Pay Premium (CPP)

Thank you for being a member of Scott and White Health Plan. Please complete the information below to tell us how you would like to pay your monthly premium. Then, sign and return this form by mail or fax to:

Scott and White Health Plan
Attn: Enrollment Dept., MS-A4-126
1206 West Campus Drive
Temple, TX 76502

Fax: 254-298-3199

Premiums are due on the first day of every month.

Member Name (first and last):	Member ID Number:	
Address:		
City:	State:	ZIP Code:
Home Phone Number: ( )	Other Phone Number (cell/mobile): ( )	
Email Address:		

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

☐ **Monthly Invoice.** Pay monthly by check/money order. *(Make payable to Scott and White Health Plan)*

☐ **Social Security Deduction.** The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction may include all premiums due. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums).

☐ **Bank Draft.** (Your account will be drafted between the 4th and 9th each month.)

Bank Account Holder Name:	
Bank Name:	Type of Account: ☐ Checking ☐ Savings
Routing Number:	Account Number:

I authorize Scott and White Health Plan to initiate monthly withdrawals in the amount of my current monthly premium, from the account named on this form and authorize the named banking facility to charge such withdrawals to my account. Please include a "VOID" check when you return this form. (Do not use a deposit slip or temporary check, since these will not be accepted.)

Bank Account Holder Signature:	Date:

Office Use Only
Effective Date: _____ Submitted By: _____

Questions? Call Customer Service: 1-866-334-3141 (TTY: 711), 7 a.m. to 8 p.m., seven days a week.
Y0058_20CPP_C