USFHP Enrollment Fee Allotment Authorization Form

JOHNS HOPKINS HEALTH PLANS

Please type or print all entries.

Name: Last	First	M.I.	Member ID

Street address *(Home)*	Apt No.	City	State	Zip Code

Email Address:

☐ Please ***Start*** a monthly allotment to Johns Hopkins Health Plans from my retirement pay for USFHP enrollment fees.

I hereby authorize this allotment to be taken from my military retirement pay.

I understand that it will remain in effect until I leave the plan for any reason or I meet criteria for an exception from the requirement to pay via allotment.

I understand that my enrollment fee may change from year to year, and I authorize the allotment amount to reflect the enrollment fee amount at the time of payment.

Sponsor Signature: _____ Date: _____

Johns Hopkins Health Plans will attempt to start the allotment from your military retirement pay by the next payment due date. You will be notified by Johns Hopkins Health Plans 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:

US Family Health Plan Enrollment Department
PO Box 8689
Elkridge, MD 21075