INITIAL DOWN PAYMENT FOR INDIVIDUAL OR MEDICARE APPLICATION PAYMENT

Group Health Cooperative
of South Central Wisconsin

Member Name:

Member Number (If known):

Phone Number:

Credit Card

☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name:

Card Number:

Expiration Date:

Billing Address for this Credit Card:

Reminder this is a onetime payment deduction

By signature below, I (we) authorize Group Health Cooperative of South Central Wisconsin (GHC-SCW) to instruct my financial institution to deduct my premium payment from the account designated above. I authorize the financial institute to debit the amount of my premium from my designate account. This authorization is a onetime deduction only.

If you would like to set up future Automatic Payments, please log on to https://ghcscw.com. Click on Health Insurance, forms, scroll down to Health Insurance Forms and click on MyChart Payment & Auto Payment Information-Insurance Premiums.

Signature: _____ Date: _____

Neither GHC-SCW nor its agents are connected with Medicare