MPHP Payment Plan Form

The Medical Professionals Health Program charges a monthly program fee to all MPHP participants actively working in their profession. In an attempt to facilitate this process, there are several payment options available for you to choose from. Please note that waivers and fee reduction options are also available.

Participant Name:_____ Date:_____

According to MPHP Policy your participation fee is: _____

Please select a payment option:

☐ **Monthly Payment by Check**

The MPHP will send you a bill on a monthly basis. Payment is due before the end of the month.
Please bill me for my monthly MPHP program fee of _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email:_____

☐ **Monthly Payment by Credit Card**

Your credit card will be automatically charged on the 15th of each month. Confirmation of payment is available upon request.

Please automatically charge my MPHP program monthly fee of _____to my credit card.

Name on Credit Card: _____

Card: ☐ Visa ☐ MasterCard
Credit card number: _____ expiration date:_____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email:_____

I prefer that invoices be sent via mail ☐ **via email*** ☐

*Payments can be made online via a payment link when receiving emailed invoices.

Authorizing Signature:_____