MPHP Reduction and Waiver Form

The Medical Professionals Health Program is committed to the health and wellbeing of all medical professionals. We understand that some participants are not working in the medical field and are unable to make these payments at this time. If you would like to request a waiver, please complete this form and explain your circumstances. Waivers are granted strictly on financial need.

Participant Name:_____Date_____

*** ***

According to MPHP Policy your participation fee is: $100 $50 $25 Other:____
(see attached policy for participation fee schedule)

☐ **I would like to request a <u>WAIVER</u>* from the MPHP monthly fee.** (explain below.)

_____ I will begin payment of the participant fee in <u>3 months</u>
_____ I will begin payment of the participation fee in <u>6 months</u>
_____ Please defer my monthly fee until (date) _____

☐ **I would like to request a <u>REDUCTION</u> in the MPHP monthly fee.** (explain below)

I believe that I can pay $_____ monthly.
Please reduce my monthly fee until _____.

Please explain briefly the reasons for you waiver/reduced payment request.

_____

_____

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_____

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* your invoices will begin automatically on the agreed upon deferment date.

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