Group Health Cooperative
of South Central Wisconsin

Initial Down Payment for Individual or Medicare Application Payment

Member Name (Print) _____ 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 for initial application payment only.

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 automatic monthly payments please complete the Automatic Payment Authorization for Medicare Select or Individual Policies which is on the back side of this form.

SIGNATURE _____ DATE _____

Mail to:
GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN, ATTN: PREMIUM BILLING,
1265 JOHN Q HAMMONS DRIVE, MADISON, WI 53717

Neither GHC-SCW nor its agents are connected with Medicare