**MedPro Group Deferred Payment Plan Enrollment**

Required Information:

* Insureds Name:
* Insureds Policy Number:
* Email Address:
* Phone Number:       *(Best number for contact)*

I/the insured am electing to participate in the 90-day grace period for my/the insured’s premium payments (including renewal down payments or installments) beginning on:

*[Select ONE Below by placing an X]*

      April 1, 2020

May 1, 2020

Upon expiration of the 90-day grace period, I/the insured would like to be enrolled in the deferred premium plan. In addition, it is understood that the deferred premium payments will be billed in 12 equal monthly installments. It is also understood that any outstanding state taxes and surcharges will be billed and due in full with the first deferred premium payment.

Note from MedPro:

**As an additional safety precaution:** Please do not include any personal financial or credit card information. If approved, a member of MedPro’s Deferred Payment Plan team will contact you / the insured to obtain consent and personal information.

Please submit this form to our [billinghelp@medpro.com](mailto:billinghelp@medpro.com) email to request consideration for the deferred payment plan.