**MedPro Group Deferred Payment Plan Enrollment**

Required Information:

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

Please allow this notice to serve as my/the insured’s written attestation of a financial hardship. In addition, it is understood that the deferred premium payments will be automatically withdrawn via my/the insured’s bank account (ACH) or charged to my/the insured’s credit card in 3 bi-monthly installments over 6 months. 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.