

Date: [Insert Date]

To: [Insurance Company Name or Billing Department]

Address: [Street Address, City, State, Zip Code]

Subject: Health Insurance Premium Payment Agreement

Account/Policy Details:

Policyholder Name: [Full Name]

Policy Number: [Insert Policy Number]

Total Outstanding Balance: \$[Insert Amount]

Dear [Contact Name or Billing Department],

This letter serves as a formal agreement regarding the payment of my outstanding health insurance premiums. I acknowledge that I owe the total balance of \$[Insert Amount] for the period of [Start Date] to [End Date].

Due to [Optional: Brief Reason for Delay], I am requesting to fulfill this obligation through a structured payment plan as follows:

- **Down Payment:** \$[Insert Amount] to be paid on [Date].
- **Installment Amount:** \$[Insert Amount] per [Month/Week].
- **Frequency:** Payments will be made on the [Date, e.g., 1st or 15th] of every month.
- **Duration:** Payments will continue until the full balance is paid, ending on or before [Final Payment Date].

I agree to make these payments on time to ensure my health insurance coverage remains active and in good standing. I understand that failure to adhere to this schedule may result in a lapse of coverage or further collection actions.

Please confirm your acceptance of this payment arrangement by signing below and returning a copy to me, or by providing written confirmation via mail/email.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Phone Number]

[Your Email Address]

Accepted By (Insurance Representative):

Signature: _____

Date: _____

Title: _____