REQUEST FOR SERVICE

Use this form to make changes to your Celtic Individual Health Plan by providing the personal information below and completing the appropriate section.

Please note that while some changes must be made in writing, others can be made simply by calling a Celtic Client Services Representative. The following can be handled **over the phone** (by the primary insured) by calling **1-800-477-7870**:

- ▲ *Name Change (due to marriage or divorce)*
- ▲ *Address or Phone Number Change*
- ▲ *Adding a Newborn to Coverage (within 31 days of birth)*
- ▲ *Changing to a Higher Deductible*
- ▲ *Changing from CeltiCare Any Doc PPO to CeltiCare Select PPO*
- ▲ *Deleting/Removing a Dependent*
- ▲ *Deleting Monthly Automatic Pay Plan*

PERSONAL INFORMATION:

Insured's Name_____ Daytime Phone (____)_____

Mailing Address_____ Certificate No._____

City/State/Zip Code_____ Agent's Name Jesse Heim III Agency # 1461

SERVICE REQUEST:

Address/Phone Number Change:

From: Address_____

_____

Phone (____)_____

To: Address_____

_____

Phone (____)_____

NOTE: An address change may affect your premium.

Name Change:

From:_____

To:_____

Adding or Removing a Dependent from My Plan:

_____Add _____Remove Name_____

_____Spouse _____Child Date of Birth_____

Reason for change_____

Signature_____

Date Signed_____

NOTE: Each new dependent (except for a newborn added within 31 days of birth) require underwriting approval. A new application must be completed, signed, dated and forwarded to our office.

Beneficiary Change, Term Life Insurance:

Beneficiary Name_____

Relationship to me_____

Signature_____

Date Signed_____

Subject to terms of the Policy, I request that the beneficiary on my Term Life Insurance be changed to the above in lieu of any prior beneficiary designations applicable, which are hereby revoked.

Terminate My Insurance Coverage:

_____Cancel my entire plan

_____Cancel Term Life Insurance

Signature_____

Date Signed_____

NOTE: Termination takes effect the first of the next month (or current paid to date) following the date that a proper request is received. Termination are not pro-rated. While notification must be in writing, please call 1-800-477-7870 to stop premium drafts until your written notification is received.

The following changes must be handled in writing. They require underwriting approval. A new application must be completed, signed, dated and forwarded to our office:

- ▲ Changing to a lower deductible
- ▲ Increasing coinsurance levels
- ▲ Adding Optional Benefits (CeltiCare Plus Option or CeltiCare Term Life Insurance)
- ▲ Deleting PPO option
- ▲ Changing from CeltiCare Select PPO to CeltiCare "Any Doc" PPO
- ▲ Adding a dependent (except for a newborn added within 31 days of birth)

Please contact your Insurance Agent or our Client Services Department at 1-800-477-7870 for application forms.

Earning your trust, every day CELTIC

CHANGE OF PAYMENT METHOD:

From: _____Monthly Automatic Pay Plan
_____Monthly Bill
_____Quarterly Bill

To: _____Monthly Automatic Pay Plan
_____Monthly Bill
_____Quarterly Bill

NOTE:
1. There is a $8 per bill charge for monthly or quarterly bill option.
2. Changing to Quarterly Bill can only be made on quarterly anniversaries from your policy effective date.
3. We will be unable to process requests for Monthly Automatic Pay Plan if the completed, signed and dated authorization form (below) and copy of voided check are not submitted with this change request. (If changing to Monthly Automatic Pay Plan or changing your account for the Automatic Pay Plan, please read the Monthly Automatic Pay Plan Agreement below, complete the requested information and enclose a voided check or savings account slip from your personal account. In some states we are unable to draft from a business account.) Drafts will take place the first business day of each month.

MONTHLY AUTOMATIC PAY PLAN AUTHORIZATION FORM

Celtic Insurance Company is hereby authorized to present checks drawn on my personal checking or personal savings account on or around the first day of each month thereafter until this authorization is terminated. I further authorize the bank named below to pay and charge to my account those payments that are drawn on my account by Celtic Insurance Company, and I agree that the bank named below shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Celtic Insurance Company in writing.

Payor Name or Depositor if different *(Please print)*: _____
FIRST MIDDLE LAST

Relationship to Applicant: _____

Signature of Primary Payor: _____ Date: _____

Name of Financial Institution: _____ Address: _____
CITY STATE ZIP

Specify type of account: ☐ Checking or ☐ Savings Checking/Savings Account Number: _____

ABA9 Digit Routing Number *(See below or please call your Financial Institution for assistance)*: _____

VOIDED CHECK

MAILING ADDRESS

Send this form to:

Celtic Insurance Company
Attention: Policy Owner Services
P.O. Box 061110, Wacker Drive Post Office
Chicago, IL 60606

Earning your trust, every day CELTIC