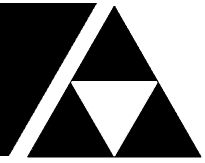


# REQUEST FOR SERVICE



**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**

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