

CELTIC 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 CelticSaver HSA Managed Indemnity to CelticSaver HSA PPO
- ▲ Changing from CultiCare Any Doc PPO to CultiCare Select PPO
- ▲ Deleting/Removing a Dependent
- ▲ Deleting Monthly Automatic Pay Plan
- ▲ Changing to a lower coinsurance level

PERSONAL INFORMATION

Insured's Name _____ Daytime Phone _____
Mailing Address _____ Certificate No. _____
City/State/Zip Code _____ Agent's Name _____

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) requires 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. Terminations 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 (CultiCare Plus Option, CultiCare Term Life Insurance, CultiCare II or CultiCare Preferred Rx Drug Card Option, Celtic Basic Rx Drug Card Option, CultiCare Preferred Supplemental Accident Option or CelticSaver HSA Preventive Care Option)
- ▲ Deleting PPO option
- ▲ Changing from CultiCare Select PPO to CultiCare "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.

CHANGE OF PAYMENT METHOD

From: ___ Monthly Automatic Pay Plan
___ Monthly Bill
___ Quarterly Bill

To: ___ Monthly Automatic Pay Plan
___ Monthly Bill (not available with Celtic Basic)
___ Quarterly Bill

NOTE: 1. CeltiCare and CeltiCare II plans have an \$8 bill fee. CeltiCare Preferred and CelticSaver HSA plans have a \$10 per bill charge for monthly or quarterly.
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: _____

Parent Grandparent Legal Guardian Other: _____

Signature of Primary Payor: _____

Date: _____

Name of Financial Institution: _____

Address: _____

CITY

STATE

ZIP

Specify type of account: Checking or Savings

Checking/Savings Account Number: _____

ABA 9 Digit Routing Number (*Please call your Financial Institution for assistance*): _____

VOIDED CHECK

Please Note: Celtic does not accept Business/Employer checks for payment for health insurance; Celtic will accept payments from sole proprietorships that are not for more than one applicant. We do not accept any type Business/Employer checks in Colorado and North Carolina.

MAILING ADDRESS

Send this form to:
Celtic Insurance Company
Attention: Policy Owner Services
P.O. Box 26110, Little Rock, AR 72221

Earning Your Trust, Every Day

CELTIC[®]