MEDAmerica
An Excellus Company

MedAmerica Insurance Company
Home Office: Pittsburgh, PA

MedAmerica Insurance Company of New York
Home Office: Rochester, NY

MedAmerica Insurance Company of Florida
Home Office: Orlando, FL

Administrative Change Form

Mailing Address: LTC Operations
165 Court Street
Rochester, NY 14647
1-800-544-0327

DATE COMPLETING/SUBMITTING THIS FORM TO COMPANY: ____/____/____.

IDENTIFYING INFORMATION CURRENTLY ON FILE:

Employing **U**nit/**D**epartment:_____

Name: _____ **S**ocial **S**ecurity #: _____

Address: _____

City: _____ **S**tate:_____ **Z**ip:_____

NEW INFORMATION: **N**ew **E**mploying **U**nit:_____

New Name: _____

New Address:_____

City: _____ **S**tate:_____ **Z**ip:_____

REQUEST TO CHANGE EFFECTIVE DATE: **(Cannot Be Greater than 60 Days from Current Effective Date)**

I wish to change my effective date from: **C**urrent **E**ffective **D**ate:_____ **TO** **N**ew **E**ffective **D**ate:_____

☛ **INSURED SIGNATURE:**_____**DATE:** _____

CANCELLATION REQUEST: I wish to cancel my long-term care insurance as of: Date to Cancel_____

☛ **INSURED SIGNATURE:**_____**DATE:** _____

BENEFICIARY INFORMATION: ❑**NEW** ❑**CHANGE**

Name: _____ **P**HONE**:** _____

Address: _____

City: _____ **S**tate_____ **Z**ip _____

☛ **INSURED SIGNATURE:**_____**DATE:** _____

MY CURRENT PAYMENT METHOD IS: (CHOOSE **1, 2 OR 3)**

1) ❑ Direct Bill **2)** ❑ Payroll/Retirement Deduction **3)** ❑ Bank Account Draft **OR** ❑ Credit Card

I WANT TO CHANGE MY PAYMENT METHOD TO: (CHOOSE **1, 2 OR 3** BELOW**)**

1) ❑ **Direct Bill: P**ayment Frequency (Choose **ONE)** ❑ Quarterly ❑ Semi-Annual ❑ Annual

☛ **INSURED SIGNATURE:**_____**DATE:** _____

2) ❑ **Payroll/Retirement Deduction (Must be pre-approved by your employer.)**

I authorize my employer/retirement system to deduct the applicable premium from my salary/retirement. I authorize the Group Policyholder or other designated party acting on behalf of the Group Policyholder to adjust these deductions based on rate changes or changes in coverage as provided by the Group Policy. I may revoke this authorization at any time by written notice to my employer/retirement system and to the Group Policyholder or other designated party acting on behalf of the Group Policyholder.

☛_____ ☛_____

Employee/Retiree Signature **Employing Unit/Department:**

3) ❑ **Bank Account Draft** **OR** ❑ **Credit Card**

Account Type (Account withdrawal is the 5th of the month.)

❑ Checking ❑ Credit Card ❑ VISA ❑ MasterCard

_____ _____

Bank Name Bank Account #

Attach Voided Check

Payment Frequency (Choose **ONE**)

❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

_____ _____

Credit Card # Expiration Date

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company/MedAmerica Insurance Company of New York (Company) or other designated party acting on behalf of the Company for my long-term care insurance premius. This authorization shall remain in force until I give notification of termination to my financial institution or credit card company and the Company or other designated party acting on behalf of the Company in writing.

☛_____ ☛_____

Signature of Account Holder **Signature of Joint Account Holder**

Agent's Signature If Applicable**: X**_____**Date** _____