



# CHANGE AUTHORIZATION REQUEST

Member Name \_\_\_\_\_ Member ID # \_\_\_\_\_

CHANGE REQUESTED (check all that apply): \_\_\_\_\_ EFFECTIVE DATE OF CHANGE: \_\_\_\_\_

- Plan Type
- Payment Information
- Billing Date
- Beneficiary
- Dependent
- Name

**PLAN TYPE CHANGE** On my next monthly billing date, please change my SureHealth coverage to a (choose one):

- |                                    |                                    |                                    |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <b>Plus 250</b>                    | <b>Plus 500</b>                    | <b>Plus 750</b>                    | <b>Plus 1000</b>                   | <b>Vitality 500</b>                | <b>Vitality 1000</b>               |
| <input type="checkbox"/> Single    | <input type="checkbox"/> Single    | <input type="checkbox"/> Single    | <input type="checkbox"/> Single    | <input type="checkbox"/> Single    | <input type="checkbox"/> Single    |
| <input type="checkbox"/> Single +1 | <input type="checkbox"/> Single +1 | <input type="checkbox"/> Single +1 | <input type="checkbox"/> Single +1 | <input type="checkbox"/> Single +1 | <input type="checkbox"/> Single +1 |
| <input type="checkbox"/> Family    | <input type="checkbox"/> Family    | <input type="checkbox"/> Family    | <input type="checkbox"/> Family    | <input type="checkbox"/> Family    | <input type="checkbox"/> Family    |

**4-Tier Prescription Plan**  Add to my existing plan  Delete from my current plan

**PAYMENT INFORMATION** (Complete this section ONLY if you are changing your current payment information)

*I hereby request and authorize Consumer Health Choice Association to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my account set forth below, for the purpose of debiting membership monthly rate for SureHealth Plans. I hereby authorize and request my financial institution to honor debit entries initiated by Consumer Health Choice Association and debit such account. This authority is to remain in effect until Consumer Health Choice Association receives a written notification from me of termination of SureHealth Plans Benefits. I further agree that if any entry is dishonored, whether with or without cause and whether intentionally or inadvertently, Consumer Health Choice Association shall have no liability whatsoever even though such dishonor results in the termination of my membership in SureHealth Plans. If payment is made by ACH transaction, the name appearing on my statement will read "Health Association"; if payment is by Credit Card, the name appearing on my statement will read "SureHealth Plans.com."*

**Automatic Bank Draft**  Checking  Savings Bank Name: \_\_\_\_\_  
Routing # (9 digits) \_\_\_\_\_ Account # \_\_\_\_\_

**Credit Card** (Check one)  Visa  MasterCard  Discover  American Express  
Name as it appears on card: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Credit Card #: \_\_\_\_\_ Security Code #: \_\_\_\_\_

**BILLING DATE CHANGE** (Members with effective dates on the first of the month may select a billing date between the 1<sup>st</sup> and 14<sup>th</sup>. Members with effective dates on the fifteenth of the month may select a billing date between the 15<sup>th</sup> and 28<sup>th</sup>.)

Please change my billing date to: \_\_\_\_\_ of the month.

**BENEFICIARY CHANGE** (Complete this section ONLY if you are changing your current beneficiary information)

Primary Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

**DEPENDENT CHANGE** (Complete this section ONLY if you are changing your current dependent information)

	<u>Name of Dependent (Last/First/Middle)</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship</u>
<input type="radio"/> Add <input type="radio"/> Delete	_____	_____	_____	_____	_____
<input type="radio"/> Add <input type="radio"/> Delete	_____	_____	_____	_____	_____
<input type="radio"/> Add <input type="radio"/> Delete	_____	_____	_____	_____	_____

Effective Date of Change: \_\_\_\_\_

**PRIMARY MEMBER NAME CHANGE** (Must attach legal proof of name change)

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Primary Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete, sign, date, and return this from to:

**SureHealth, PO Box 15398, Plantation, FL 33318** or fax to **954-315-6325**.

If you have any questions, please call **1-800-337-1421**