P.O. Box 14533
Oklahoma City, OK 73113
1-888-524-3629

REQUEST FOR SERVICE

POLICY NUMBER MPOLICY	INSURED MINSNAME	MEDICARE ID NUMBER

CHANGE NAME OF: ☐ Insured ☐ Payor

FORMER NAME (please print)	NEW NAME (please print)

REASON FOR CHANGE (If other than correction, marriage or divorce, please attach copy of legal evidence; if available.)

☐ DUPLICATE POLICY REQUEST	☐ DUPLICATE ID CARD REQUEST
☐ CHANGE OF ADDRESS (Indicate new address.)	☐ CANCELLATION OF FREE LOOK ☐ CANCELLATION OF POLICY
☐ CHANGE OF TELEPHONE NUMBER (Indicate new telephone number.)	☐ NOTIFICATION OF DEATH (Please include death certificate)
☐ CHANGE PAYMENT METHOD ☐ QUARTERLY DIRECT ☐ SEMI-ANNUAL DIRECT ☐ ANNUAL DIRECT ☐ MONTHLY EFT ☐ QUARTERLY EFT ☐ SEMI-ANNUAL EFT ☐ ANNUAL EFT ***IF selecting EFT option please contact a Customer Service Associate at 1-888-524-3629.**	☐ REQUEST TO REDUCE/INCREASE BENEFITS ☐ Supplement Plan A ☐ Supplement Plan B (PA Residents ONLY) ☐ Supplement Plan C (OH and NJ Residents ONLY) ☐ Supplement Plan D ☐ Supplement Plan F ☐ Supplement Plan G ☐ Supplement Plan N ***ALL benefit changes are subject to underwriting approval.**

COMPLETE FOR ABOVE REQUEST

_____ _____
Signature Date