



CHANGE FORM

<input type="checkbox"/> Member Information (Required for all change requests)	First Name	M.I.	Last Name	
<input type="checkbox"/> Change of Address <input type="checkbox"/> Physical Address Change <input type="checkbox"/> Billing Address Change <input type="checkbox"/> Both <input type="checkbox"/> Does change apply to other covered family members? If yes, attach a separate page listing name and Pool member ID # for each family member.	Address	City	State	Zip
<input type="checkbox"/> Deductible Change If deductible change is requested for other covered family members, complete a separate Change Form for each family member affected. NOTE: A deductible change is effective the first of the month following receipt of this form by the Pool Administrator. A change to a lower deductible is not allowed.	Member ID #	Telephone Number		
<input type="checkbox"/> Cancellation of Coverage If cancellation of coverage applies to other covered family members, attach a separate page listing name and Pool member ID # for each family member affected.	Plans for Non-Medicare Eligibles <input type="checkbox"/> Plan II R \$2,500 Medical Deductible, \$200 Rx Deductible <input type="checkbox"/> Plan III R \$5,000 Medical Deductible, \$200 Rx Deductible <input type="checkbox"/> Plan IV R \$7,500 Medical Deductible, \$500 Rx Deductible <input type="checkbox"/> Plan V R HDHP/HSA-Qualified, \$3,000 Medical Deductible, \$1,250 Rx Deductible Plans for Medicare Eligibles <input type="checkbox"/> Plan II M \$2,500 Medical Deductible, (No Rx Benefit)			
<input type="checkbox"/> Smoker/Non-Smoker Change If another covered family member has a change in Smoker/Non-Smoker status, complete a separate change form for that family member.	I wish to cancel my Pool coverage. I understand that I may not be allowed to reapply to the Pool for 12 months following the effective date of this cancellation. My reason for cancellation is:			
<input type="checkbox"/> Change in Payment Method A change in payment method applies to all covered family members. Attach a separate page listing name and Pool member ID # for each covered family member.	My use of Tobacco Products has changed: <input type="checkbox"/> I Have <input type="checkbox"/> I Have Not Smoked Cigarettes, Cigars, or a Pipe or used Chewing Tobacco, Nicotine Chewing Gum or Snuff in The Last Twelve (12) months. *A physician's statement is required.			
	Please change my payment method to: <input type="checkbox"/> Monthly, Automatic Withdrawal (Complete Authorization Agreement for Automatic Withdrawal on back and include a voided check.) <input type="checkbox"/> Quarterly Bill <input type="checkbox"/> Semi-annual Bill <input type="checkbox"/> Annual Bill			
I hereby certify that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until this change form is approved and any required additional premium is received. I understand that if I or any other person covered by the Pool policy no longer meets Pool eligibility requirements, the Pool Administrator must be notified and Pool coverage will end.				
Signature of Member X	Date	Signature of Parent or legal guardian (If Member is under age 18 or legally incompetent) X	Date	

Mail this form to: Texas Health Insurance Pool
 P. O. Box 660819
 Dallas, TX 75266

Questions? Call: 1-888-39-TEXAS (1-888-398-3927)
 Fax: 1-325-793-4134
 Web site: www.txhealthpool.org

Complete this section only if you are requesting to pay premiums monthly.

Authorization Agreement for Monthly Automatic Bank Deduction of Insurance Premium

Complete and sign the Authorization Agreement for monthly Automatic Bank Deduction of Insurance Premium if you have chosen monthly payments. Please note:

- **Attach** a sample of your check marked "VOID".
- Verify your account number with your banking institution. (Frequently, the account number listed on a check includes or removes digits from the actual account number.)

As a convenience to me (or us if this is a joint account), I (we) hereby request and authorize you to pay and charge to my (our) account checks or electronic debits drawn on my (our) account by you and payable to the order of the Texas Health Insurance Pool. I (we) agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me (us). This authority is to remain in effect until revoked by me (us) in writing and until you actually receive such notice. I (we) agree that you shall be fully protected in honoring any such check or electronic debit.

I (we) further agree that if any such check or electronic debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Name of Account Holder(s)

1. _____ 2. _____

Bank Name			Checking Account Number: (Do not use a savings account.)	
Bank Address				
City	State	Zip Code	Routing Number:	

Signature of Account Holder(s)

Name (please print)		Name (please print)	
Signature	Date	Signature	Date
X		X	

To The Financial Institution named: In consideration of your participating in a plan which the Texas Health Insurance Pool ("Company") has put into effect by which amounts due on policies of insurance are collected by checks drawn or pre-authorized electronic debits originated by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check or electronic debit, whether or not genuine, originated by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you whether with or without cause, or intentionally or inadvertently, of any such check or electronic debit, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check or electronic debit; and

(2) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check or electronic debit if claim for the amount of such erroneous payment is made by you within six months from the date of the check or electronic debit on which such erroneous payment was made; and

(3) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other, likewise, your participation and that of the Texas Health Insurance Pool may be terminated by 30 days written notice from either party to the other.

Texas Health Insurance Pool

D. Gregory Barbutti
 Secretary/Treasurer
 Authorized in a resolution adopted by the Board of Directors