CHANGE FORM

TEXAS Health Insurance Pool

❑ **Member Information** (Required for all change requests)	First Name	M.I.	Last Name	
❑ **Change of Address** ❑ Physical Address Change ❑ Billing Address Change ❑ Both ❑ 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
	Member ID #	Telephone Number		
❑ **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.***	**Plans for Non-Medicare Eligibles** ❑ Plan II R $2,500 Medical Deductible, $200 Rx Deductible ❑ Plan III R $5,000 Medical Deductible, $200 Rx Deductible ❑ Plan IV R $7,500 Medical Deductible, $500 Rx Deductible ❑ Plan V R HDHP/HSA-Qualified, $3,000 Medical Deductible, $1,450 Rx Deductible **Plans for Medicare Eligibles** ❑ Plan II M $2,500 Medical Deductible, (No Rx Benefit)			
❑ **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.	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:			
❑ **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.	My use of Tobacco Products has changed: ❑ **I Have** ***❑ 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.**			
❑ **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.	Please change my payment method to: ❑ Monthly, Automatic Withdrawal (Complete Authorization Agreement for Automatic Withdrawal on back and include a voided check.) ❑ Quarterly Bill ❑ Semi-annual Bill ❑ 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	Date	Signature of Parent or legal guardian (If Member is under age 18 or legally incompetent)	Date
X		**X**	

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 **X**	Date	Signature **X**	Date

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