

Billing Change Form

Instructions

1. You may use this form to change your billing option for your coverage under the Federal Long Term Care Insurance Program. First, fill in your name and Social Security number below and any personal information that has changed since your original application. Then, continue on to select the billing option of your choice.
2. You may also use this form to consolidate your direct billing with another enrollee or have your premiums deducted from another employee or annuitant's pay. Simply provide the information in the appropriate section on the reverse side of this form. If someone else will be paying your premiums through payroll/annuity deduction, that person must also sign the authorization in the payroll or annuity/pension deduction section of this form.
3. To find a payroll/annuity office identifier, visit our website at www.LTCFEDS.com/payroll. For questions, please call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557).

When completed, please return the form in the provided envelope or mail it to the following address:
 Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797. Or you can fax the form to 603-430-6479.

Personal information

First name Middle initial

Last name

Social Security number

Street address

City State/territory

Country Zip/foreign postal code

Check here if this is a foreign address

Home phone Work phone

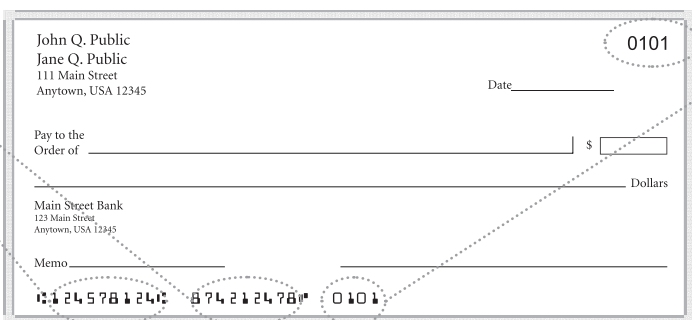
Email

Automatic bank withdrawal

I authorize Long Term Care Partners to initiate automatic bank withdrawals from the account number provided below. Withdrawals will begin the month after Long Term Care Partners (LTCP) receives this form and will continue on the third business day of every month. I understand that any past due premium will be collected by withdrawing up to 2 months of premium from my account until current. This authorization will remain in effect until I, my bank, or LTCP terminate(s) it by a 30-day written notice to the others. I understand that I will not receive any bills or other notices of the withdrawals from LTCP. I agree that if the automatic bank withdrawal is not honored by my bank, for whatever reason, LTCP will have no liability for the payments. I understand that my insurance coverage may be terminated because of non-payment of premiums. I also understand that I will receive notice of such non-payment from LTCP before my coverage is terminated.

Routing number: Account number:

Below is a sample check detailing where to find the information necessary to complete this section. Please take the time to verify that the information you are providing is correct in order to avoid a delay in the implementation of this billing method on your account.



Checking account #
(Always between these 2 marks)

Routing/transit #
(A 9-digit number always between these 2 marks)

Check #
(Not needed for billing change)

The signature of depositor(s) as shown on bank records for this account is required. If joint account, both depositors must sign.

Depositor's signature _____ Date signed _____
 (Required) (Required—mm/dd/yy)

Account type (choose one): **Checking** (We do not accept money market accounts) **Savings**

