Complete
Personal and Direct Care

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Premium Payment Method Change Request

Section 1 General Information	
Member Name:	Facility Name (If applicable):
Member ID Number:	Date of Birth:
Authorized Representative Name *(If applicable):*	Authorized Representative Phone Number:

Authorized Representative is for legal representative only.

Section 2 Current Premium Payment Method	
☐ Coordinate Payment Through My Facility	☐ Receive a Bill

Section 3 New Premium Payment Method	
☐ Coordinate Payment Through My Facility	☐ Receive a Bill
Effective Date of Change:	

Effective date of change must be on the first of the month.

Section 4 Signature	
By signing below I declare to the best of my knowledge and belief that the information provided is true and correct, and understand the premium payment method will be updated to the new selection type reflected on this form.	
Member, POA, or Legal Responsible Party Signature:	Date:
Facility Representative Signature *(If applicable)*:	Date: