INCLUSIVE HEALTH
Insuring Individuals with Medical Conditions

**FOR OFFICE USE ONLY**
**Approved by:**

**Effective Date: _____**

# CHANGE FORM

**** Please type or print in black or blue ink

## Applicant Information (ALL members must complete this section) –

| Last Name | First Name | Middle Initial | | |
|---|---|---|---|---|
| **Address** | **City** | **County** | **State** | **Zip code** |
| **Member ID #** | **Date of Birth** | **Telephone #** | **Email Address** | |

☐ **Address Change -** Is the address provided above a new address?

☐ **Coverage Change -** (Changes in coverage will be effective on the anniversary date of your current policy):

- ☐ **PPO 1000 - $1000 deductible**
- ☐ **PPO 2500 - $2500 deductible**
- ☐ **PPO 3500 - $3500 deductible**
- ☐ **High Deductible5000 - $5000 deductible**

**** More information on the each plan can be found at:**
http://www.inclusivehealth.org/pages/15/benefit-coverage/

☐ **Smoker/ Non-Smoker rate change**

**I HAVE _____ or HAVE NOT _____ smoked cigarettes, cigars, used a pipe or chewing tobacco, nicotine chewing gum or snuff in the last 12 months**
**(This change must be accompanied by a Doctor's statement)**

☐ **Cancellation of Coverage -** I wish to cancel my current health insurance coverage under Inclusive Health to be effective on: _____

My reason for cancellation is: Too expensive ___ Obtained Group Coverage ___ Medicare eligible ___ Moved ___ Other individual coverage ___ Other: _____

*** **I understand that I will not be eligible to reapply to Inclusive Health for 12 months following the effective date of this cancellation**

**I hereby certify the forgoing statements are true and accurate to the best of my knowledge and belief. I understand that no change will become effective until approval by Inclusive Health. I understand that if I obtain other health insurance coverage including Medicare, Medicaid, SCHIP or other group coverage or move out of the state of North Carolina, I must notify Inclusive Health and my Inclusive Health benefits will end.**

_____ _____ _____

**Signature of the Member** **Date** **Signature of Parent or Legal Guardian**

**Mail this form to:** **Inclusive Health**
**PO Box 30909**
**Raleigh, NC 27622**

**Email Address: Contactus@inclusivehealth.org**
**Website: www.inclusivehealth.org**
**Customer Service Center – (866) 665-2117**

**Failure to complete and return this form with any changes will result in your current plan option remaining the same as it currently is and you will not be able to make any changes until your next open enrollment period.**

# BANKING INFORMATION

**ALL MEMBERS MUST COMPLETE THIS SECTION**

**The only available option for your monthly premium payment is via automatic withdrawals taken directly from your checking or savings account, commonly referred to as Electronic Funds Transfer (EFT). Please complete the authorization agreement below and submit a voided check.** Your automatic deduction will be made on the last business day of each month for the following month of coverage. In the event that your automatic withdrawal does not go through, Inclusive Health reserves the right to add any overdue amounts to the next automatic withdrawal to keep your premium payments current. Failure to pay your premium within the 31 day grace period will result in termination of coverage.

***An EFT is NOT required for HCTC eligible individuals.**

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# Authorization Agreement

## Banking Information

_____
**Name of the insured (Applicant)**

_____
**Name of the Financial Institute**

**Financial Institute Address:**

_____

_____

_____ _____ _____
**City** **State** **Zip Code**

_____
**Name of the Account Holder (please print)**

_____ _____
**Signature** **Date**

_____
**Name of the Joint (Additional) Account Holder**

**Type of Account**
☐ **Checking** ☐ **Savings**
**Please attach a voided check**

_____
**Account Number**

_____
**Routing Number**

_____
**Name of the Joint Account Holder (please print)**

_____ _____
**Signature** **Date**

**TO FINANCIAL INSTITUTION:** In consideration of honoring preauthorized checks/ drafts drawn against depositors of your financial institution for the payment of amounts to Inclusive Health, we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such checks/ drafts, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such checks/ drafts.

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**Approved by:**
**Effective Date:**

**Customer Service Center 1-866-665-2117**
**Email:** contactus@inclusivehealth.org
**Website:** www.inclusivehealth.org