

CELTIC REQUEST FOR SERVICE

Use this form to make changes to your Celtic Health Plan by providing the personal information below and completing the appropriate section.

The following can be handled **over the phone** by the Primary Insured. Call a Celtic Client Services Representative at **1-800-477-7870** for assistance.

- Name change (due to marriage or divorce)
- Address or phone number change
- Adding a newborn to coverage (within 31 days of birth)

GENERAL INFORMATION:

Please fill out completely.

Insured's Name: _____ Date of Birth: / / _____
Mailing Address: _____
City: _____ State: _____ Zip _____
Daytime phone: _____ Certificate number: _____

SERVICE REQUEST INFORMATION:

Select the Service Request needed and provide the information requested.

Name change:

From: _____ To: _____

Address/phone number change:

From: Address: _____

Phone: _____ Email: _____

To: Address: _____

Phone: _____ Email: _____

Removing a dependent from my plan: Spouse Child

Name: _____ Date of birth: _____

Reason for change: _____

Signature of Primary Applicant: _____ Date: _____

Terminate my insurance coverage:

Termination takes effect the first of the next month (or current paid to date) following the date that a proper request is received. Terminations are not pro-rated. **While notification must be in writing, please call 1-800-477-7870 to stop premium drafts until your written notification is received.**

Signature of Primary Applicant: _____ Date: _____

Signature of dependent over age 18: _____ Date: _____

PAYMENT INFORMATION & AUTHORIZATION:

Monthly Billing: Paper bill Payor Information

Relationship to Primary Applicant: Self Parent Legal Guardian Other _____

Name & Billing Address if different from Primary Applicant's Current Residential Address:

NAME STREET CITY STATE ZIP

MAILING ADDRESS

Send this form to:

Celtic Insurance Company, Attn: Policy Owner Services, P.O. Box 26110, Little Rock, AR 72221 or fax to: 1-800-600-8796.