MediQ65®

Medicare Supplement Insurance from QualChoice

MediQ65® Plan Change Request Form

Instructions: Mail completed form to QualChoice, Attn: Marketing, P.O. Box 25626, Little Rock AR 72221 or fax to 501.707.6765. For questions, call a MediQ65 sales representative at 855.633.4765 or 501.228.7111.

Requested Effective Date (mm/dd/yyyy) ▶ _____

Section I. Member Information

First Name	MI	Last Name

Gender ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	Member ID#

Primary Phone Number	Secondary Phone Number	Email Address

Residential Street Address	City	State	Zip Code
Billing Address (if different from residential address)	City	State	Zip Code
Mailing Address (if different from residential address)	City	State	Zip Code

Section II. Plan Change Request

Plan and premium changes will be effective the first day of the month after we receive this form. Please submit changes by December 15, 2017 to allow us time to set up your new premium in our billing system. If there is a rate difference, you may receive a credit or have to pay the difference if the new rate is higher. This will be reflected on the next month's invoice.

Check ☑ the box of the plan you want to change to.

Premium	☐ Plan A	☐ Plan F	☐ Plan G	☐ Plan K	☐ Plan N	☐ Plan F-HD
Monthly Rate*	$112.53	$172.46	$141.65	$62.43	$118.05	$56.06
Quarterly Rate	$337.59	$517.38	$424.95	$187.29	$354.15	$168.18

**A $2.00 monthly service charge applies to monthly paper billing.*

Section III. Authorization

By signing below, I authorize QualChoice to change my MediQ65 plan and premium rate to the plan I have checked above. I understand this change will be effective on the first day of the month after QualChoice has received this form.

Printed Name of Member	Signature of Member	Date Signed (MM/DD/YYYY)

Printed Name of Broker	Signature of Broker	Date Signed (MM/DD/YYYY)