

ADDRESS CHANGE REQUEST

All address change requests must be submitted in writing. Use this form to request a permanent change of address. Please allow 30 days for the address change to be processed.

Policyholder's Name: _____

Claimant's Name: _____

Policy Number(s):

PLEASE CHANGE MY ADDRESS TO:

Address: _____

City: _____ State _____ Zip code _____

Effective Date of Change: _____

(This address change will remain in effect until further written notification is received.)

Name of person completing this form (please print): _____

Signature of Policyholder (or Legal Representative)

Date Signed (Month/Date/Year)

Policyholder (or Legal Representative) Name (Please Print)

Signed at (City/County/State)

If Legal Representative, give relationship to Policyholder
(Attach a copy of your legal authority, Power Of Attorney, guardianship, etc. if applicable)

PLEASE NOTE:

This address change will affect all correspondence being sent to the policyholder by Bankers, such as: Premium Statement, Claim Checks, Explanation of Benefits (EOB).

This form **must be signed and dated by the policyholder or Legal Representative** in order to be considered valid. Without proper signature(s) or documentation, this document is null and void.

If you have further questions please feel free to contact our Customer Service Department at 1-800-621-3724 between the hours of 8:00 AM – 4:30 PM Central Time, Monday through Friday.

Please mail Address Change Request Form to:

Policy Benefits Department
PO Box 1902
Carmel, IN 46082-1902
Or
Fax to: 312-396-5952