



M-Pel

Policy Number 9938

## Change Form

Enrollees can use this form to change their name or address, the method or frequency with which they pay their premiums, or to cancel their coverage. **Please remember to sign and date on the bottom of this form.** You can fax it to CNA at: (407) 919-1880, or mail it to:

CNA Customer Service  
P O Box 946760  
Maitland, FL 32794-9776

If you have questions, please call customer service at 1-888/653-9600, send an e-mail message to [cnagroupecustomerservice@lfcg.com](mailto:cnagroupecustomerservice@lfcg.com), or visit our website: [www.mpel.org](http://www.mpel.org).

### Notice of Intent to Collect Private Data

Some of the information we ask for on this form is private data as defined in the Minnesota Government Data Practices Act (Minn. Stat. Ch. 13).

1. When you enrolled in our long-term care insurance plan, you provided us with your Social Security number. We need this information again so we can correctly identify you in our files and accurately make the changes you are requesting.
2. If you have changed your address, we need your new address so we can continue to communicate benefit information to you.
3. If you choose to make payments through electronic funds transfer, we need your account number and name, address and phone number of your financial institution in order to transfer funds.

You are not legally required to provide the above information. However, without it, we will have difficulty fulfilling our responsibilities. Your private data will only be available to CNA employees who will be processing your request.

#### Enrollee information

First Name	M.I	Last Name	Social Security Number:
			- -

#### 1. Change name

I wish to change my name in your records to:

First Name	M.I	Last Name

#### 2. Change address

I wish to change my address in your records to:

Number and Street	City	State	Zip

### 3. Change payment method

<input type="checkbox"/> I wish to change my method by which I am paying for coverage.
<b>Current method (choose one):</b>
<input type="checkbox"/> Payroll deduction <input type="checkbox"/> Direct bill -- Frequency: <input type="checkbox"/> monthly <input type="checkbox"/> quarterly <input type="checkbox"/> semi-annually <input type="checkbox"/> annually <input type="checkbox"/> Monthly electronic funds transfer
<b>New method (choose one):</b>
<input type="checkbox"/> Payroll deduction <input type="checkbox"/> Direct bill -- Frequency: <input type="checkbox"/> monthly <input type="checkbox"/> quarterly <input type="checkbox"/> semi-annually <input type="checkbox"/> annually <input type="checkbox"/> Monthly electronic funds transfer
<input type="checkbox"/> For monthly electronic funds transfer, deduct my monthly premium from: <input type="checkbox"/> Checking account (include a VOIDED check) <input type="checkbox"/> Savings account (include a VOIDED deposit slip)

#### Financial institution

Name		Phone	
Number and Street		City	State Zip

Note: Changes from payroll deduction to direct bill or electronic funds transfer will not take effect until the first of the month following the date the request is processed. Changes from direct bill or electronic funds transfer to payroll deduction will not take effect for approximately two pay cycles after the request is processed.

### 4. Change payment frequency

<input type="checkbox"/> I wish to change my payments(choose one):
<input type="checkbox"/> From nine months to twelve months a year. <input type="checkbox"/> From twelve months to nine months a year.

Note: Changing to nine months requires that enrollee be paid on nine-month basis. Changes in payment frequency will not take effect for approximately two pay cycles after the request is processed.

### 5. Cancel coverage

<input type="checkbox"/> I wish to cancel my long-term care insurance coverage.
<input type="checkbox"/> As soon as possible <input type="checkbox"/> As of _____

Note: Cancellations for coverage on direct bill or electronic funds transfer will not take effect until the first of the month following the date the request is processed. Coverage on payroll deduction will not take effect for approximately two pay cycles after the request is processed.

#### Please sign and date

Enrollee Signature	Date
Daytime phone number	

Fax to 877-914-2358, or mail to CNA, PO Box 946760, Maitland, FL 32794-6760