The Federal Long Term Care Insurance Program

BILLING CHANGE FORM

INSTRUCTIONS:

1. You may use this form to change your billing option for your coverage under The Federal Long Term Care Insurance Program. First, fill in your name and Social Security Number below, and any other personal information that has changed since your original application. Then continue on to select the billing option of your choice.
2. You may also use this form to consolidate your direct billing with another enrollee or have your premiums deducted from another employee or annuitant's pay. Simply provide that person's name and Social Security Number in the appropriate section below. If someone else will be paying your premiums through payroll/annuity deduction, that person must also sign the authorization in the Payroll/Annuity Deduction section of this form.
3. For questions about the payroll or annuity deduction option, please refer to the Payroll/Annuity Deduction Instruction Guide on our website (www.LTCFEDS.com) or call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557).

When completed, please return in the provided envelope or mail to:

Long Term Care Partners, LLC
100 Arboretum Drive, Suite 100
Portsmouth, NH 03801-7833

PERSONAL INFORMATION:

Name _____
FIRST MIDDLE INITIAL LAST

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

If any of the following personal information has changed, please update in the spaces below.

Street Address _____

_____

_____

City _____ State/Territory _____

Country _____ ZIP/Foreign Postal Code _____

☐ **Check here if this is a Foreign Address**

Home Phone _____

Work Phone _____

Email _____

CHANGE BILLING OPTION:

CHANGE TO DIRECT BILLING:

☐ **Check here if you wish to pay through DIRECT BILLING. You may request an alternate billing address by filling out the information below. If you check here and leave this blank, we will use the address we have on record or the address you provided above.**

Care Of _____
FIRST MIDDLE INITIAL LAST

Street Address _____

_____

_____

City _____ State/Territory _____

Country _____ ZIP Code/Foreign Postal Code _____

☐ **Check here if this is a Foreign Address**

If you are consolidating direct billing with another enrollee, please provide his/her name and Social Security Number.

Name _____
FIRST MIDDLE INITIAL LAST

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

CHANGE TO AUTOMATIC BANK WITHDRAWAL:

☐ **Check here if you wish to pay through AUTOMATIC BANK WITHDRAWAL (Automatic Bank Withdrawals occur on the third business day of every month). Complete this Authorization, attach a voided check or a voided savings account deposit slip and then sign below:**

Name of bank (and branch if applicable) ***Checking/Savings Account No.***

_____ _____

I authorize Long Term Care Partners to initiate automatic bank withdrawals from my account shown above. I also authorize my bank to charge my account shown above for such withdrawals, payable to Long Term Care Partners.

This authorization will remain in effect until either I, my bank or Long Term Care Partners terminates it by a thirty (30) day written notice to the others. I understand that I won't receive any bills or other notices of the withdrawals from Long Term Care Partners.

I agree that if the automatic bank withdrawal isn't honored by my bank, for whatever reason, Long Term Care Partners will have no liability for the payments. I understand that my insurance coverage may be terminated because of non-payment of premiums. I also understand that I will receive notice of such non-payment from Long Term Care Partners before my insurance coverage is terminated.

Staple Voided Check or Voided Savings Deposit Slip Here

Depositor's Signature X_____ **Date** ____ / ____ / ____
MONTH / DAY / YEAR

Depositor's Signature X_____ **Date** ____ / ____ / ____
MONTH / DAY / YEAR

Signature must be signature of depositor(s) as shown on bank records for this account. If joint account, both depositors must sign.

CHANGE TO PAYROLL/ANNUITY DEDUCTION:

☐ **Check here if you wish to pay through PAYROLL/ANNUITY DEDUCTION. You must provide a Payroll/Annuity Office Identifier and any other information required below. You may find the Payroll/Annuity Office Identifier within your *Payroll/Annuity Deduction Instruction Guide* or visit www.LTCFEDS.com. You may also call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557) for assistance. The person from whose pay/annuity deductions will be taken must also sign the authorization below.**

Please provide the Payroll/Annuity Office Identifier for the Payroll/Annuity Office from which deductions will be made.

Payroll/Annuity Office Identifier: **(5 - 8 DIGITS/CHARACTERS)**

If deductions will be made from a Federal/Civilian annuity, and there is an Annuity Claim Number, please provide it:

Annuity Claim Number: C S

INSERT (A, F, OR I) ABOVE AND FILL IN THE REMAINING 8 DIGITS/CHARACTERS OF YOUR ANNUITY CLAIM NUMBER

If you are requesting payroll/annuity deduction from someone else's pay/annuity, that person must complete the information above, provide the following information, and sign the authorization below:

Name of Employee/Annuitant _____
FIRST MIDDLE INITIAL LAST

Social Security Number of Employee/Annuitant: ____ - ____ - ____

Payroll/Annuity Authorization Signature X _____ **Date** ____ / ____ / ____
MONTH / DAY / YEAR

I authorize Long Term Care Partners to deduct from my pay/annuity the amount necessary to pay the premiums for the Federal Long Term Care Insurance coverage issued to me or my qualified relative. This authorization may be cancelled only upon written notification to Long Term Care Partners from me or my qualified relative.

John Hancock MetLife®

Sponsored by the U.S. Office of Personnel Management
The Federal Long Term Care Insurance Program is administered by Long Term Care Partners, LLC, and offered by:
John Hancock Life Insurance Company, Boston, MA
Metropolitan Life Insurance Company, New York, NY