

BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD N., ST. PETERSBURG, FLORIDA 33716

TELEPHONE: (866) 987-9844 FAX: (727) 803-2094

[WEBSITE: www.BankersHealthPlans.com](http://www.BankersHealthPlans.com)



Bankers
Health
Plans

Change Request

SECTION 1: Personal Information

Name: _____ Policy Number: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

SECTION 2: Type of Change

Change of Address – New Address

Street Address: _____ City: _____ State: _____ Zip: _____

Remove child(ren) as a result of:

Reaching maximum age for coverage and not a student (25 years old) - (No Conversion requested)

Reaching maximum age for coverage (30 years old) - (No Conversion requested)

Name of child _____ Date of Birth: _____ Social Security Number: _____

Name of child _____ Date of Birth: _____ Social Security Number: _____

Marriage - Date of marriage _____

Death of Primary Insured- (No Conversion requested)

Add spouse due to

Marriage: Please provide a written application for Coverage and Evidence of Insurability. Must meet Bankers Underwriting Guidelines

Date of marriage _____ Name of spouse _____ Date of Birth: _____

Remove spouse due to: (Name of Primary Insured _____ Date of Birth: _____)

Divorce – Date divorce finalized _____ - (No Conversion requested)

Active Armed Forces duty – Date Active Duty begins: _____

Death of Primary Insured - (No Conversion requested)

Conversion of this policy because: (Name of Primary Insured _____ Date of Birth: _____)

This change request must be received within 60 days of qualifying event

Child is no longer an eligible dependant – Child Conversion

Divorce – Spouse conversion

Death of Primary Insured – Spouse conversion

SECTION 3: Authorization

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony in the third degree.

By signing below, you agree to the terms set forth in your individual contract. You also affirm that this information, as presented, is complete and accurate to the best of your knowledge. This form replaces information contained in previous forms and submissions made to Bankers Insurance Company / Bankers Health Plans.

I hereby declare the change request was signed and dated at _____ on _____ / _____ 20____ Year

Signature of Insured: _____ Date: _____

**Please mail to: Bankers Health Plans 11101 Roosevelt Blvd N., St. Petersburg, FL 33716 or
Fax to: (727) 803-2094**