Billing Change Form

1. You may use this form to change your payment option for your coverage under the Federal Long Term Care Insurance Program (FLTCIP). First, provide your name, Social Security number, and any personal information that has changed since your original application. Then, continue to the payment section 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's or annuitant's pay. Simply provide the information in the appropriate section on the reverse side of this form. If someone else will be paying your premiums through payroll or annuity/pension deduction, that person must also sign the authorization in the payroll or annuity/pension deduction section of this form.
3. BENEFEDS administers the premium payment processes on behalf of the FLTCIP. If you have questions about your premium payments, please call our Customer Service Center at **1-877-888-FEDS** (1-877-888-3337) **TTY** 1-877-889-5680.

Note: You may also change your payment option online. If you have been approved for coverage and you receive a direct bill, you may change your payment option to automatic bank withdrawal by visiting **BENEFEDS.com** and logging into your My BENEFEDS account.

First name | M.I. | Last name

Social Security number

Address

City | State/territory

Country | Zip/foreign postal code

☐ Check here if this is a foreign address

Home phone | Mobile phone

Email

Choose one

Automatic bank withdrawal

☐ I authorize Long Term Care Partners (LTCP), LLC, to initiate recurring automatic bank withdrawals from the account number provided. I authorize my bank to charge this account for such withdrawals. Withdrawals will begin the month after I am approved for coverage and will continue on the third business day each month thereafter. I understand that if a withdrawal is not honored by my bank for any reason, LTCP has no liability for the payments and I am responsible to pay my premium or my insurance coverage will be terminated. I understand that if two consecutive withdrawals are not honored by my bank for any reason, my billing method may change to direct bill. I understand that any past due premium will be collected by withdrawing up to two months of premium at a time from my account until my premiums are current. I understand that I will not receive any bills or other notices of the withdrawals from LTCP. I understand that my insurance coverage may be terminated for nonpayment of premiums. I also understand that I will receive notice of such nonpayment from LTCP before my coverage is terminated. I understand that I must contact LTCP at least 10 business days prior to the next scheduled withdrawal to revoke this authorization.

Choose one: ☐ **Checking** ☐ **Savings**

We do not accept money market accounts.

Routing number | Account number

Depositor's signature X _____
(Required)

Date signed _____/_____/_____
(Required: mm/dd/yy)

Continued

or

Payroll or annuity/ pension deduction

Visit our website at **LTCFEDS.com/agency-search** to find a payroll or annuity office identifier.

☐ **My pay or annuity/pension**
I authorize LTCP to deduct premiums from my pay or annuity/pension. I have provided my Social Security number on the reverse side of this form.

Choose one: (Insert **A, F, or I** below and fill in the remaining seven or eight characters)

☐ **CSRS/FERS annuity deductions** CS

☐ **All payroll or other annuity/pension deductions**

Office identifier

or

☐ **Someone else's pay or annuity/pension**
If you are requesting that deductions be taken from someone else's pay or annuity/pension, that employee or annuitant must complete this section and sign the authorization below.

Choose one (Insert **A, F, or I** below and fill in the remaining seven or eight characters)

☐ **CSRS/FERS annuity deductions** CS

☐ **All payroll or other annuity/pension deductions**

Office identifier

☐ Mr. ☐ Mrs. ☐ Ms.

Payor's first name | M.I. | Last name

Payor's Social Security number

I authorize LTCP to deduct from my pay or annuity/pension that amount necessary to pay the premiums for the FLTCIP coverage for this enrollee.

Payor's signature X _____ (Required)

Date signed _____/_____/_____ (Required: mm/dd/yy)

or

Direct bill

☐ **Please send me a direct bill monthly to the address I provided on the reverse side of this form.**

If you want to consolidate direct billing with another enrollee, please provide his or her name and Social Security number.

First name | M.I. | Last name

Social Security number

☐ **If this person is the payor, check here.**

Please return your completed form by fax to **1-603-430-6479** or by mail to **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797**.

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, and administered by Long Term Care Partners, LLC.

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