Instructions:

To change your method of payment to Credit Card on your MedAmerica Life Insurance Company of New York Long-Term Care Policy, please complete the following sections of the Administrative Change Form and return it to Charles J. Sellers & Co., Inc.:

DATE COMPLETING/ SUBMITTING THIS FORM TO COMPANY	**Please insert the date the form is being completed**
IDENTIFYING INFORMATION CURRENTLY ON FILE	**Please insert your Name, Address, City, State, Zip Code and Social Security number.**
MY CURRENT PAYMENT METHOD IS	**Please check "Direct Bill"**
In 3)	➢ **Select Credit Card** ➢ **Select Payment Frequency (i.e., Monthly, Quarterly, Semi-Annual or Annual).** ➢ **Insert the Credit Card #.** ➢ **Insert the Expiration Date.**

The Account Holder will need to sign the form where indicated. If there is a Joint Account Holder, that individual will need to sign the form as well.

Please mail, fax or e-mail the completed form to:

Charles J. Sellers & Co., Inc.

P.O. Box 460, 4300 Camp Road
Athol Springs, NY 14010

FAX: 716-627-5420 (Buffalo area) or toll-free 1-800-462-1121 (Outside Buffalo area)

E-mail: insurance@sellersinsurance.com

Should you have any questions concerning this form, or if we can be of assistance in any way, please phone our Customer Sales Department at 716-627-5400 (Buffalo area) or toll-free 1-800-333-5440 (Outside Buffalo area). Representatives are available to assist you Monday-Friday, 8:30 A.M. to 5:00 P.M.

MEDAmerica
An Excellus Company
MedAmerica Insurance Company
Home Office: Pittsburgh, PA
MedAmerica Insurance Company of New York
Home Office: Rochester, NY

Administrative Change Form

Mailing Address: LTC Operations
165 Court Street
Rochester, NY

DATE COMPLETING/SUBMITTING THIS FORM TO COMPANY: ______/______/______.

IDENTIFYING INFORMATION CURRENTLY ON FILE:

Employing Unit/Department: __________
Name: ______________________________ Social Security #: __________
Address: ______________________________
City: __________ State: __________ Zip: __________

NEW INFORMATION: New Employing Unit: __________
New Name: ______________________________
New Address: ______________________________
City: __________ State: __________ Zip: __________

REQUEST TO CHANGE EFFECTIVE DATE: **(Cannot Be Greater than 60 Days from Current Effective Date)**
I wish to change my effective date from: Current Effective Date: __________ **TO** New Effective Date: __________
☛ **INSURED SIGNATURE:** ______________________________ **DATE:** __________

CANCELLATION REQUEST: I wish to cancel my long-term care insurance as of: Date to Cancel __________
☛ **INSURED SIGNATURE:** ______________________________ **DATE:** __________

BENEFICIARY INFORMATION: ❑ **NEW** ❑ **CHANGE**
Name: ______________________________ **PHONE:** __________
Address: ______________________________
City: __________ State __________ Zip __________
☛ **INSURED SIGNATURE:** ______________________________ **DATE:** __________

MY CURRENT PAYMENT METHOD IS: (CHOOSE **1, 2 OR 3**)
1) ❑ Direct Bill **2)** ❑ Payroll/Retirement Deduction **3)** ❑ Bank Account Draft OR ❑ Credit Card

I WANT TO CHANGE MY PAYMENT METHOD TO: (CHOOSE **1, 2 OR 3** BELOW)
1) ❑ **Direct Bill:** Payment Frequency (Choose **ONE**) ❑ Quarterly ❑ Semi-Annual ❑ Annual
2) ❑ **Payroll/Retirement Deduction** **(Must be pre-approved by your employer.)**

I authorize my employer/retirement system to deduct the applicable premium from my salary/retirement. I authorize the Group Policyholder or other designated party acting on behalf of the Group Policyholder to adjust these deductions based on rate changes or changes in coverage as provided by the Group Policy. I may revoke this authorization at any time by written notice to my employer/retirement system and to the Group Policyholder or other designated party acting on behalf of the Group Policyholder.

☛ ______________________________ ☛ ______________________________
Employee/Retiree Signature **Employing Unit/Department:**

3) ❑ **Bank Account Draft** OR ❑ **Credit Card**
Account Type (Account withdrawal is the 5th of the month.)
❑ Checking ❑ Credit Card
❑ VISA ❑ MasterCard
Payment Frequency (Choose **ONE**)
❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

__________ Bank Name **Attach Voided Check** __________ Bank Account #
__________ Credit Card # __________ Expiration Date

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company/MedAmerica Insurance Company of New York (Company) or other designated party acting on behalf of the Company for my long-term care insurance premius. This authorization shall remain in force until I give notification of termination to my financial institution or credit card company and the Company or other designated party acting on behalf of the Company in writing.

☛ ______________________________ ☛ ______________________________
Signature of Account Holder **Signature of Joint Account Holder**

If Applicable:
Agent's Signature: X ______________________________ **Date** __________

9/20/03 (rev)