Please return completed form to: customerservice@sniprotect.com

Change Form

Primary Member ______________________ Member ID# ____________ SSN ____________

Please complete the appropriate section

Personal Information Changes

Name Change	
First Name:	Last Name:

Contact Info Change	
Phone:	Email:

Address Change			
Street:	City:	State:	ZIP:

Dependent Changes

Only complete this section if you are adding or removing a dependent.

Please fill out all fields, including the reason code column. Use the reason codes listed to the right. If you need to add more than two dependents, please complete another form.

Reason Codes

1) Marital status change
2) Birth/adoption
3) Loss of coverage
4) Death
5) Other ____________

Dependent 1

Name:	Relationship:	DOB:	Gender:	SSN:	Add/ Remove	Reason Code:

Dependent 2

Name:	Relationship:	DOB:	Gender:	SSN:	Add/ Remove	Reason Code:

Complete the below section if you are adding a dependent

In the past 24 months, has the family member(s) being added to the plan been 1) diagnosed with a medical condition, 2) treated for a medical condition, or 3) exhibited any signs/symptoms of a medical condition? **YES/NO**

If YES, please list all conditions below using one line per condition.

Applicant's Name:	List condition / ailment / injury:	Is treatment ongoing? (Y/N)	Is condition completely cured? (Y/N)	Date treatment ended (if applicable)

Please refer to your SNI plan documents to determine if your plan has coverage limitations for pre-existing conditions.

Signature ______________________ Date ______________________

Payment Information Changes

Only complete this section if you are changing/updating payment information

Banking/EFT			
First Name:	Last Name:	Bank Name:	Account Type (Select One) ☐ Checking ☐ Savings
Account Number:		Routing Number:	

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Sovereign Nations Insurance in writing of any changes in my account information within 15 days. This authorization is required for plan administration. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF), I understand that Sovereign Nations Insurance or its assigned third party may at its discretion attempt to process the charge again within 30 days, and agree to an additional $20 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring contribution. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

Transactions will appear on your account as Sovereign Nations Insurance

Credit Card				
First Name:	Last Name:	Credit Card #:	Card Type	Exp. Date

☐ I have read, understand, and acknowledge the information above and authorize these transactions by signing my full legal name below.

____
Print Name

____
Signature

____
Date