Mark all boxes and complete all sections that apply. Email, fax, or mail completed form to:

Ryan Insurance Strategy Consultants
5690 DTC Boulevard, Suite 290W, Greenwood Village, CO 80111
www.Ryan-Insurance.net
info@Ryan-Insurance.net
(800) 796-0909 Fax 888-337-2291

CHANGE FORM

I wish to make the following change/s to my participation in the AAPA Group Disability Insurapce:

Change the bank account used for my monthly premium withdrawal:

Account Type: Checking Savings
Name of Financial Institution: ______________________________
Location (City, State): ______________________________
New Account Number: ______________________________
Financial Institution's Routing/Transit Number: ______________________________
(Look between symbols "/:/:" on your check)
YOU MUST PROVIDE A COPY OF A VOID CHECK FOR THIS TRANSACTION

Update Contact information:

Address: home work ______________________________
____
Email: ______________________________
(Your email will be used to contact you with plan information throughout the year)
Phone: work mobile home ______________________________

Submit a change of name

New last name: ______________________________

End my participation in the CCRC'Disability Insurance Plan(s)

Please provide the reason why your participation is ending, so that we may continue to improve our service. (There is Conversion Option which may be available upon termination of your participation. Contact us for details)

____

Requested date of cancellation: ______________ (*Premiums are calendar month; no partial month refund)*

Important:
You must be a member of AAPA to continue to participate in this plan.
Benefits from most other group DI plans will offset benefits from the AAPA DI Plans.
Call us to discuss if you have other group coverage or if your eligibility has changed.

____
Signature

____
AAPA Member ID Number

____
Print Name

____
Email address

____
Date

***Please allow two weeks for the requested changes to be made. You will receive confirmation via email of completion*.**