KEYSTONE HEALTH PLAN EAST
INDIVIDUAL HMO COVERAGE PROGRAM

[DATE]

[MEMBER NAME]
[ACCOUNT ID NO.]

I have reviewed the enclosed Individual HMO Benefits Chart.

Effective **[Date]**, change my Individual HMO Option Plan to the following plan:

____ HMO $15 Copay at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $20 Copay at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $1500 Deductible at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $2500 Deductible at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

____ HMO $5000 Deductible at a monthly premium of [**Amount]** for [**Single] [Family]** coverage.

I understand that if at some future date I wish to change back to the HMO Option Plan in force prior to this change, that such request will be subject to medical underwriting.

MEMBER SIGNATURE________________________________ DATE____________

SPOUSE SIGNATURE__________________________________ DATE____________

Mail this completed form to: Independence Blue Cross
Individual Medical Underwriting
P.O. Box 41474
Philadelphia, PA 19101-1474