



CORRECTION WORKSHEET

Proposed Insured Information (Must complete for all corrections.)

Name: _____ Policy # / SSN #: _____ Date: _____

Description of Corrections to be Made

- | | |
|--|---|
| <input type="checkbox"/> Bank Correction | <input type="checkbox"/> Face Amount/Premium Correction |
| <input type="checkbox"/> Recording Correction | <input type="checkbox"/> Agent Statement |
| <input type="checkbox"/> Redraft | <input type="checkbox"/> Medication/Usage |
| <input type="checkbox"/> Replacement/Existing Coverage | <input type="checkbox"/> Physician Name/Address |
| <input type="checkbox"/> Other _____ | |

Payor/Payment Account Information (This section MUST be complete for all payment corrections.)

Name on Account (This person must sign below): _____

Account Type: (circle one) Checking / Savings / Direct Express

Routing Number: _____ Account Number: _____

Revised Withdraw Date (must be future date): _____

Due date for future monthly payments: (circle one) 1st 3rd 5th 10th 15th 20th 25th

Payor's Signature: _____ Date: _____

Check here if Payor's Signature is a voice signature on a Correction Recording that accompanies this form.

Agent Name: _____ Agent #: _____

Agent Signature: _____ Date: _____

**Important! We do not accept corrections by e-mail.
All corrections should be placed in the Citrix ShareFile Corrections Folder.**