Inshore Benefits
Group Enrollment Checklist
Globe Life Indemnity Plan

Available to groups headquartered in one of these States: CA

- ❑ **Employer Application includes three items:**
  - ❑ **Group Application**
  - ❑ **New Case Information Form (NCIF)**
  - ❑ **Proposal Signature Page**

- ❑ **First Month's Premium** (include $5 monthly admin Fee*)
  - ❑ If paying by ACH autopay AND enrolled in emailed invoices only.
  - ❑ If paying by check, make check payable to Pathian Administrators.
  - ❑ If paying by ACH, complete ACH Auto pay form.

- ❑ **Employee Applications** or Census Enrollment Spreadsheet
  (Minimum of 10 enrolled employees required)

Three Ways to Submit:

- ❑ **Mail to:**
  Warner Pacific Insurance Services
  Attn: Inshore New Business
  32110 Agoura Road
  Westlake Village, CA 91361-4026

- ❑ **Fax to:**
  (818) 484-2975

- ❑ **Email to:**
  CANewBusiness@warnerpacific.com

Once the new policy has been approved, it is the employer's responsibility to cancel any prior coverage per the carrier's cancellation policy in order to avoid being responsible for additional premium.

Globe Life And Accident Insurance Company
3700 S Stonebridge Dr
McKinney, TX 75070
www.globelifebenefits.com

Group Limited Indemnity Policy

GROUP INSURANCE APPLICATION

GENERAL INFORMATION

Full Legal Name of **PARTICIPATING EMPLOYER**:	Federal Tax ID #:

Street Address: City: County: State: Zip:

Form of Organization:
☐ Corporation ☐ Proprietorship ☐ Partnership

Full Legal Name of **TRUST:** _____

Requested Effective Date of Insurance: _____ (MM/DD/YYYY)

List all Subsidiaries to be included:_____

ELIGIBILITY, CONTRIBUTION AND BENEFIT SELECTIONS (for benefits and plan features, see sold proposal)

 # ELIGIBLE EMPLOYEES:

_____

ELIGIBLE CLASS(ES):

☐ Full-Time ☐ Permanent
☐ Part-Time ☐ Temporary
☐ Both ☐ Seasonal

HOURS REQUIRED PER WEEK (if no minimum hours required, put "0")**:**

_____

ELIGIBLE DEPENDENTS:

☐ Spouse
☐ Domestic Partner
☐ Children
☐ Not Offered

EARLY RETIREES ELIGIBLE:

☐ Yes ☐ No

EMPLOYER CONTRIBUTION:

_____ % $_____

Other:_____

ANNUAL BENEFIT MAXIMUM BASIS:

☐ Calendar Year
☐ Benefit Year: _____ to _____

COVERAGE CONTINUATION SELECTIONS:

☐ None ☐ COBRA ☐ Continuation ☐ Leave of Absence for _____ ☐ weeks ☐ months

REPLACEMENT:

Will all or part of this policy replace similar coverage? ☐ No ☐ Yes
If yes, please list: Insurer:_____ Policy Number:_____ Termination Date:_____
Has pre-ex credit been approved for time on prior plan? ☐ N/A ☐ No ☐ Yes

AGREEMENT *(This form must be signed)*

The Participating Employer and Globe Life And Accident Insurance Company ("We", "Us" or "Our") agree that:

The **APPLICATION** signed by the Trustee will form the basis for and become part of any policy issued. This **APPLICATION** should form the basis for and become part of any coverage issued to your Insureds. The effective date of the insurance is subject to approval of this application by Globe Life And Accident Insurance Company. The request to participate in the Policy issued to the Trust does not make the Participating Employer a Policyholder. If the applicant is accepted as a Participating Employer, it will receive a copy of the Certificate(s) to be issued for delivery to Insureds.

PREMIUM RATES shall:

1. be subject to all provisions in that policy; and
2. be binding on the Trust, the Participating Employer and Us.

LIABILITY OF THE COMPANY: We will have no liability until this request has been approved at Our Administrative Office.

AUTHORITY OF AGENTS: No agent can change the terms of this request or any policy We issue. No agent can waive any of Our rights or requirements or extend the time for any premium payments.

CHANGES AND CORRECTIONS: The acceptance of any policy issued on this request shall constitute ratification of any correction or amendment made by Us. Changes are an amendment to and form a part of the original request and any policy issued.

ELECTRONIC COMMUNICATION: An applicant that affirmatively consents to receive electronic communications has the right to obtain, at no additional cost, written communications in paper or other non-electronic form. An applicant may request non-electronic communications and/or withdraw consent to receive electronic communications through mail or verbally at any time. Consent may be withdrawn from specific transactions or identified categories or written communication. The Company does not impose any conditions for withdrawing consent. An applicant is responsible for accessing, opening, and reading policy documents. In order to receive and view electronic communications from Us, an applicant must have access to the Internet, a valid email address, and a software program for reading PDFs. The Company will notify the applicant in advance should the requirements to access or retain electronic records change. By indicating consent below, an applicant confirms it can access, view and retain electronic communications in the manner described above. An applicant who cannot access or read any policy document, or who wishes to correct or change the applicant's email address, should contact Us.

Does the applicant agree to receive electronic communications? ☐ Yes ☐ No

Email address for electronic communications: _____

Please identify withdrawal of consent for electronic communications from specific transactions or categories, if any:

_____

THE POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL TO HEALTH INSURANCE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THE POLICY DOES NOT SATISFY THE MINIMUM ESSENTIAL COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT.

AUTHORIZATION AND ACKNOWLEDGMENT

I certify that the above information is true and correct to the best of my knowledge and belief.

Please continue to read below for special notices required by state law.

Participating Employer (full legal name): _____

Date Signed _____ (MM/DD/YYYY)

Dated at _____ (City/State)

Signature of Authorized Person:	Print Name:	Print Title:
Signature of Licensed Resident Agent:	Agent Name and License Number:	Agent Address (Including Zip Code):

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Massachusetts, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any act material thereto may be guilty of fraud as determined by a court of law, and may be subject to criminal and civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or

misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

New Case Information Form - submit to: GLBImplementation@Globe.Life

Globe Life Benefits
3700 S Stonebridge Dr
McKinney, TX 75070
GLBImplementation@Globe.Life

Required Documents (please include with your submission):
- ☐ Signed Group Application for each product
- ☐ Signed Proposal for each product
- ☐ Employee enrollment

SECTION 1: GENERAL INFORMATION

Full legal name of Employer:	Renewal Month:
Nature of business:	NAICS/SIC Code:

Situs State: Do you have eligible employees residing outside of the Situs State? ☐ No ☐ Yes

If yes, please list the state(s) and number of employees that reside in each state below (attach additional sheet if needed)

State:	# EEs:	State:	# EEs:	State:	# EEs:

SECTION 2 : GROUP CONTACT INFORMATION

Contact Name:	Title:
Email:	Phone:

Is Contact Address the same as the one shown on the Group Application? ☐ Yes ☐ **No** - **If No**, please complete address info below:

Address:	City:	State:	Zip:

☐ Please check here if this address should be used for all group correspondence in lieu of the group address on the Group Application

SECTION 3: ELIGIBILITY AND EFFECTIVE DATES

Open Enrollment Effective Date:

☐ On Policy Effective date/Policy Anniversary
☐ Other: _____

New Hire Effective Date: (Terminations are processed at the end of established coverage periods)

☐ Date of Hire
☐ First coverage period following Date of Hire
☐ First coverage period following completion of _____ ☐ days ☐ weeks ☐ months of continuous employment
☐ First coverage period of the month following completion of _____ ☐ days ☐ weeks ☐ months of continuous employment
☐ Other: _____

SECTION 4: ENROLLMENT INFORMATION

Enrollment Start Date:	Enrollment End Date:	Date enrollment will be submitted:
Eligibility Contact:	Phone:	Email:

How will enrollment be submitted:

☐ Spreadsheet enrollment: Is spreadsheet attached? ☐ No ☐ Yes
☐ Payroll system file feed: Name of Payroll vendor: _____
☐ Third party electronic enrollment (APPROVAL REQUIRED) | Name of Vendor: _____

SECTION 5: BILLING INFORMATION

Is Group Billing Contact the same as the **Group Contact** in **Section 2**? ☐ Yes ☐ **No** - **If No**, please complete address info below:

Billing Contact Name:	Title:
Email:	Phone:

Address:	City:	State:	Zip:

Premium Administrator (NOTE: APPROVAL IS REQUIRED to establish a Premium TPA as the billing contact)*

Is a Premium Administrator involved in collection and remittance of premium on behalf of the Employer? ☐ No ☐ **Yes**

If Yes, Have you attached a **Premium Collection Agreement**? ☐ Yes ☐ No | Premium TPA Name: _____
Premium TPA Contact: _____ Phone: _____ Email: _____

Requested Billing Type (check appropriate boxes): **Grace Period:** 31 days **Bill Format:** PDF Excel

Bill Type: ☐ List bill ☐ Self-Reported ☐ Other_____	Frequency: ☐ Monthly ☐ Pay Cycle*	Remittance: ☐ In Advance ☐ In Arrears

***If Pay Cycle,** coverage periods will correspond to pay periods; coverage must begin on the first day and end the last day of a pay period.

Pay Frequency: Monthly-12 Semi-Monthly- 24 Bi-Weekly -26 Weekly-52

Initial Coverage Period Start Date: _____/Day:_____ Initial Coverage Period End Date: _____/Day: _____
(If group will have multiple pay periods, please attach a list of billing locations with the pay frequency and start/end dates/days for each)

Name of COBRA administrator (if COBRA is elected)**:**

Globe Life Benefits

Proposal Acceptance

Group Name: _____

Proposal Date: _____

Check the plans you wish to offer your group and sign and date below to indicate acceptance of the Globe Life plan design(s) & rates in the proposal referenced above:

Plan(s) Selected: ☐ **Plan 1** ☐ **Plan 2**

My signature below confirms acceptance of the benefits and rates in the attached proposal and signifies my request for Globe to proceed with implementation of my group.

I understand and agree that benefits and rates are subject to the provisions in the policy and that Globe has no liability until the Group Application has been approved at our Administrative Office.

Print Name _____

Title _____

Signature _____

Date _____

NOTE: If the rates shown in the proposal combine Globe Life Benefits premium with other insurance policies and or non-insurance products, we will provide you with the separate premium for each quoted product upon request.

PREMIUM COLLECTION AGREEMENT

This Premium Collection Agreement (the "**Agreement**") is entered into effective as of the date last written below ("**Effective Date**"), by and between _____ (the "**Administrator**"), and _____ (the "**Employer**"). Each of Administrator and Employer may be referred to herein as "**Party**" and collectively as the "**Parties**."

WHEREAS, Employer authorizes Administrator to serve as its premium collection administrator for purposes of handling all billing, collection and remittance of premiums on the behalf of Employer in connection with certain insurance policies/certificates issued to the employees of Employer by Globe Life And Accident Insurance Company ("**Insurer**"), and Administrator agrees to serve in the capacity of premium collection administrator with respect to the aforementioned insurance policies/certificates.

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and the mutual promises set forth below, Employer and Administrator agree as follows:

1. Authorization. Employer designates Administrator as Employer's agent for all matters relating to the receipt of premium billings from and payment of premiums to Insurer in connection with the insurance policies/certificates issued by Insurer to Employer and its employees. Employer authorizes Insurer to recognize Administrator as Employer's agent and to send all premium billings to Administrator on a schedule agreed to by the Parties and Insurer.

2. Compliance. Administrator shall comply with all applicable federal and state laws and regulations relative to the performance of its duties and responsibilities hereunder.

3. Premium Collection Duties and Responsibilities. Administrator shall have the following duties and responsibilities:

    a. Administrator shall submit timely premium billings to policy/certificate holders.

    b. Administrator shall hold all premiums collected in a fiduciary capacity, established in a federally insured financial institution for payment to Insurer. Upon receipt of premium due Insurer, Administrator shall promptly deposit (and, in any event, within seventy-two (72) hours of receipt) funds in the fiduciary account. The funds shall remain there until distributed to Insurer.

    c. Administrator shall remit all premiums due to Insurer within five (5) business days of receipt from policy/certificate holders. Payment of the premium shall be accompanied by complete and accurate records to substantiate the payment in such form and detail as may be prescribed by Insurer.

    d. Administrator shall deliver any premium refunds or other payments to policy/certificate holders within five (5) business days of receipt of same from Insurer.

e. Administrator shall maintain adequate records of all transactions under this Agreement and it shall maintain any separate accounts required by state law. Administrator may not commingle premiums received under this Agreement with funds in its general account.

f. Administrator shall provide various accounting and reporting, via electronic transmission, of files in a format mutually agreed upon by Employer and Administrator, including but not limited to, premium collected, remitted and refunded and any other reports deemed necessary by Employer to comply with all applicable state requirements.

g. Employer or its representatives shall have the right, at its sole expense, upon advance written notice to the Administrator and during normal work hours, to audit or review the Administrator's records, procedures and files on insurance policies and attached riders and any other related financial records or other documents prepared hereunder, provided that such audit or review does not interfere with the normal operation of the Administrator. This service agreement and all records and files pertaining thereto shall be maintained during the term of this agreement and for ten years thereafter.

h. The Administrator agrees to permit Employer or its agents or attorneys, at its sole expense, upon advance written notice to the Administrator and during normal working hours, to conduct an internal audit to determine whether the Administrator is in compliance with obligations, duties and responsibilities as set forth in this agreement.

i. If the Administrator is delinquent in either accounting for or paying monies due to the Insurer, then the Employer may, by written notice to the Administrator, suspend or modify any of the provisions of this Agreement or immediately terminate this Agreement.

j. Administrator shall not assign its interest or delegate its duties under this Agreement without the prior express written consent of the Employer.

4. Indemnification. Administrator shall and hereby agrees to indemnify, defend, and hold Insurer, its successors and assigns harmless, against and in respect of any and all liabilities, losses, claims, demand, damages, losses, suits, proceedings, fines, penalties, costs, and expenses, including, but not limited to, reasonable attorney's fees, resulting from or arising out of Administrator's acts, errors or omissions, and those acts of its officers, directors, employees, or agents in the performance of Administrator's obligations under this Agreement.

5. Termination. This Agreement shall terminate upon the occurrence of the earliest of any of the following: (a) mutual agreement of the Parties; (b) thirty (30) days prior written notice by either Party to the other Party; (c) Administrator's mishandling of premium funds, embezzlement of funds or other violation of relevant statutes or regulations; (d) Insurer ceases to insure any employees of Employer; or (e) the bankruptcy, liquidation or cessation of business of or by any of the Parties.

Upon the termination of this Agreement, Administrator shall promptly provide Employer with all information and support needed for Employer to continue to process its business.

6. Confidentiality.

a. As used herein, **"Confidential Information"** means the Employer's confidential, proprietary or trade secret information, including, but not limited to, underwriting criteria and guidelines, product information procedures and processes, studies, reports, compensation arrangements, and any other data or information developed by the Employer and provided to the Administrator or which is subject to protection under any federal or state privacy law. Notwithstanding the foregoing, except with respect to Personal Information, Confidential Information will not include information that: (i) is in the public domain prior to disclosure by the disclosing Party; (ii) becomes part of the public domain other than as a result of a breach of this Agreement by the receiving Party; (iii) is lawfully in the receiving Party's possession prior to disclosure by the disclosing Party; (iv) is independently developed by the receiving Party with no reference to the disclosed Confidential Information; or (v) is obtained or was previously obtained by the receiving Party from a third person who was not prohibited from transmitting the information by a contractual, legal or fiduciary obligation to the disclosing Party.

b. The receiving Party shall maintain the confidentiality of the Confidential Information, shall use it only for purposes of this Agreement, and shall not disclose it to any other person except to employees, agents and other representatives who need to know such Confidential Information to further the objectives of this Agreement.

c. The receiving Party will use the same care and discretion to avoid disclosure, publication or dissemination of the disclosing Party's Confidential Information as the receiving Party uses with its own Confidential Information of like character that it does not wish to disclose, publish or disseminate (but in no event less than a reasonable degree of care). The Parties will inform their respective employees and representatives receiving the other Party's Confidential Information of the confidential nature of the information and cause all such employees and representatives to abide by the terms of this Agreement.

d. In the event that the receiving Party becomes legally compelled (by deposition, interrogatory, request for documents, order, subpoena, civil investigative demand or similar process issued by a court of competent jurisdiction or by a governmental body or regulatory authority) to disclose the disclosing Party's Confidential Information, the receiving Party shall give prompt written notice to the disclosing Party and cooperate with the disclosing Party so that an appropriate protective order or other relief may be sought.

e. The Parties agree that money damages are not sufficient as a remedy for any breach of this Section 6, and that, in addition to all other remedies, each Party will be entitled, as a matter of right and without the need to prove irreparable injury, to seek specific performance and injunctive or other equitable relief as a remedy for any such breach.

f. At a Party's request, and/or upon expiration or termination of this Agreement, the other Party will return, or certify the destruction of, all of the requesting Party's Confidential Information in Administrator's possession or control, as requested by the requesting Party.

7. Miscellaneous. This Agreement shall be governed by and construed in accordance with the laws of the State of Texas without giving effect to any choice or conflict of law provision. No assignment of this Agreement shall be valid without the prior written consent of the Employer. No waiver, amendment or modification of this Agreement shall be effective unless it shall be in writing and signed by both Parties. If any provision of

this Agreement is found to be invalid or unenforceable by a governmental authority or court of law, all the other provisions of this Agreement will remain valid and enforceable as if this Agreement did not contain the invalid or unenforceable provision.

IN WITNESS WHEREOF, authorized officers of the Parties hereto have signed this Agreement as of the Effective Date.

EMPLOYER	**ADMINISTRATOR**
Legal Name: _____	Legal Name: _____
Signature: _____	Signature: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Inshore Benefits

Electronic-Funds Transfer Authorization Form (ACH)

I am returning this authorization to Pathian Administrators, authorizing Pathian Administrators and the financial institution named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify Pathian in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of any entry by notifying my financial institution (7) days before my account is charged.

Please return this completed form and a copy of a voided check to:

Pathian Administrators
32110 Agoura Road, Westlake Village, CA 91361
or
inshore@pathianadministrators.com

1. CLIENT INFORMATION

Client Name:		
Billing Reference #:	**Contact Phone #:**	
Client Address:		
City:	**State:**	**Zip:**

2. FINANCIAL INSTITUTION INFORMATION

(Please enter the name/address of the bank and account you wish payments to be withdrawn from)

Name of Bank:	**Branch:**	
Bank Address:		
City:	**State:**	**Zip:**

☐ Voided Check Attached	**Signature (x):** _____ *(This is your authorization for Pathian Administrators to withdraw funds from your account)*

Please check one: ☐ Checking ☐ Savings	***Note:*** *Withdrawals from your bank account will occur on the 1st working day of each month for which the premium is due.*
Bank Routing #: *The routing code is the 9-digit number on the lower left of your check. The routing code appears between the ⑆ symbols.* ⑆ _____ ⑆	**Account #:** *Your account number can be found between the second ⑆ symbol and the ⑈ symbol. Do not include the check number (the digits to the right of the ⑈ symbol.* ⑈ _____ ⑈

Cut here and retain for your records.

On (date) _____, I authorized Pathian Administrators to initiate electronic entries to my checking/savings account and have agreed to the terms listed on the authorization. I may revoke my authorization with the company at any time by writing to Pathian Administrators at the address above. *If the payment amount changes, we will notify you at least 10 days before the regularly scheduled payment date.*