FARM BUREAU HEALTH PLANS

Home Office: P.O Box 313, Columbia, TN 38402-0313, 877-874-8323

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE COVERAGE

GROUP POLICY NUMBER: 100204

GROUP POLICYHOLDER: TENNESSEE RURAL HEALTH IMPROVEMENT ASSOCIATION

PLEASE PRINT CLEARLY AND USE BLACK INK

County Office or FBHP Representative Use Only			
Subgroup	County Office	FBHP Representative	Requested Effective Date

Section 1 – Insured Person (Owner)

First Name	MI	Last Name

Date of Birth	Age	Gender	Social Security No.	Marital Status
		☐ Male ☐ Female		☐ Single ☐ Married

Mailing Address (please include your apartment or suite number)

City	County	State	Zip Code

Phone No. ( ) _____ - _____ Alternate No. ( ) _____ - _____

Email Address (by providing your email address, you agree to receive electronic communications from Farm Bureau Health Plans)

Tobacco Use: ☐ No ☐ Yes within the last 12 months ☐ Yes more than 12 months ago

☐ Yes ☐ No

Are you an existing Tennessee Farm Bureau member? If "No", please submit a Tennessee Farm Bureau Membership Application. If "Yes", please complete the following information:

Tennessee Farm Bureau membership is in the name of: _____

Tennessee Farm Bureau Membership Number: _____

Section 2 – Medicare Supplement Insurance Plan Selection

Select Medicare Supplement Insurance plan (check one plan)

☐ Plan A ☐ Plan D ☐ Plan G ☐ Plan N

Section 3 – Medicare Card Information

Please complete the following section exactly as it appears on your Medicare Card. We cannot consider this application complete until we have obtained this information. If you are not enrolled in both Medicare Part A and Part B, you are not eligible to apply for this Medicare Supplement coverage. If you are enrolled in a Medicare Advantage Plan, you are not eligible to apply for this Medicare Supplement coverage.

Name	Medicare Number

Hospital (Part A) Coverage Start Date	Medical (Part B) Coverage Start Date

Farm Bureau HEALTH PLANS Tennessee

First Name | MI | Last Name

Section 3 – Important Coverage Information

PLEASE READ CAREFULLY

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy will be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in, a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning Medicaid.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of Medicare Supplement Insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of the Medicare Supplement plans offered under Tennessee Rural Health Improvement Association group policy. Please include a copy of the notice from your prior insurer with your application.

Farm Bureau HEALTH PLANS Tennessee

First Name | MI | Last Name

Section 4 – General Questions	
Please answer all questions to the best of your knowledge:	
1. Did you turn age 65 in the last six (6) months?	☐ Yes ☐ No
2. Are you enrolled in Part A (Hospital) of Medicare?	☐ Yes ☐ No
3. Are you enrolled in Part B (Medical) of Medicare? (a) If "No," give your expected effective date _____	☐ Yes ☐ No
4. Are you covered for medical assistance through the state Medicaid program? **Note to Applicant:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. (a) If "**Yes**," will Medicaid pay your premiums for this Medicare Supplement policy? (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
5. Are you under age 65 and eligible for Medicare due to a disability?	☐ Yes ☐ No

Section 5 – Other Coverage Information	
1. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO or PPO)? If "**Yes**," fill in your start and end dates and answer the questions below. (**Please Note:** Your original start date may not be the date on your current ID card with the other plan. If you are still covered under the plan, provide the expected end date.) BEGIN DATE_____ END DATE OR EXPECTED END DATE_____ (a) If you are still covered under the above Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (b) Was this your first time in this type of Medicare plan? (c) Did you cancel any Medicare Supplement Insurance policy to enroll in this Medicare plan?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
2. Do you have another Medicare Supplement Insurance policy in force? If "**Yes**," answer the following questions: (a) With what company? _____ (b) What Medicare Supplement Insurance plan do you have? _____ (c) Please provide the original effective date of the Medicare Supplement. _____ (d) Do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No ☐ Yes ☐ No

Farm Bureau HEALTH PLANS Tennessee

First Name | MI | Last Name

3. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? If "**Yes**," answer the following question: (a) With what company and what kind of policy? _____ (b) What are your dates of coverage under the other policy? BEGIN DATE _____ END DATE OR EXPECTED END DATE _____ **Please Note:** If policy is still active, provide the expected end date.	☐ Yes ☐ No
4. Do you intend to replace your current health care coverage with this Medicare Supplement Insurance policy?	☐ Yes ☐ No

Section 6 – Medical Questions

Please answer the following questions to the best of your knowledge.

If you are applying within six (6) months of turning age 65 or obtaining Medicare Part B, whichever occurs last, or if you are within a guaranteed issue time period, you do not have to answer these questions.

In the last five (5) years, has a licensed member of the medical profession provided medical advice or treatment for:

☐ Yes ☐ No	1. Heart Attack or Congestive Heart Failure?	If "Yes," when?
☐ Yes ☐ No	2. Cancer (Not Skin Cancer)?	If "Yes," when?
☐ Yes ☐ No	3. Stroke or Trans Ischemic Attack (TIA)?	If "Yes," when?
☐ Yes ☐ No	4. Kidney Failure or Chronic Kidney Disease?	If "Yes," when?
☐ Yes ☐ No	5. Diabetes?	If "Yes," when?
☐ Yes ☐ No	6. Parkinson's Disease?	If "Yes," when?
☐ Yes ☐ No	7. Multiple Sclerosis or Lou Gehrig's Disease (ALS)?	If "Yes," when?
☐ Yes ☐ No	8. Muscular Dystrophy?	If "Yes," when?
☐ Yes ☐ No	9. Emphysema or COPD?	If "Yes," when?
☐ Yes ☐ No	10. Alzheimer’s Disease or Dementia?	If "Yes," when?
☐ Yes ☐ No	11. Cirrhosis of the liver?	If "Yes," when?
☐ Yes ☐ No	12. Huntingdon’s disease?	If "Yes," when?

Please list any prescription drugs (print full medication name) you are currently taking:

First Name	MI	Last Name

Section 7 – Acknowledgements and Agreements

PLEASE READ CAREFULLY

I understand and acknowledge:

Tennessee Rural Health Improvement Association (Farm Bureau Health Plans or "FBHP") is entitled to rely solely on the statements made on this enrollment application to be complete and correct to the best of my knowledge and beliefs.

I understand and acknowledge that the Medicare Supplement Insurance policy which may be issued:

- Will be effective, subject to all the terms and conditions of the Certificate, upon approval of my enrollment application by FBHP; the effective date will be indicated on my ID card and in my Certificate.
- Shall be binding only if each statement included on the application is complete and true to the best of my knowledge.

I understand and acknowledge the following:

- If my enrollment application is not submitted during an open enrollment period or guaranteed issue period, FBHP have the right to reject my application and any premiums paid will be refunded.
- I understand that this Medicare Supplement Insurance policy will not pay for benefits for hospital confinement beginning or medical expenses incurred during the first six (6) months of coverage if they are due to conditions for which medical advice was given or treatment recommended by a physician within six (6) months prior to the effective date of my Certificate. Coverage is not limited if I satisfy creditable coverage requirements.
- I have received an Outline of Coverage. I understand that the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication will be provided with my Certificate.
- I have the right to examine the Certificate. If I find that I am not satisfied with the Certificate, I may return it to FBHP. If I send the Certificate back to FBHP within 30 days after I receive it, FBHP will treat the Certificate as if it had never been issued and return all of my payments to me less any claims paid.
- Premium for my Certificate will be based on my current age and will be adjusted annually with each birthday.

Farm Bureau HEALTH PLANS Tennessee

First Name MI Last Name

Section 7 – Acknowledgements and Agreements (Continued)

I authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm having any information necessary to determine my eligibility for coverage under the group policy, to give all such information to FBHP. I (or my personal representative) may request a copy of this authorization.

I understand the information in this enrollment application and any information obtained with this authorization will be used by FBHP to determine eligibility for coverage and that coverage will be affected by this information. I understand that this authorization is valid for 24 months.

I declare that all the foregoing statements provided by me in this enrollment application in its entirety are true, correct and complete to the best of my knowledge and beliefs.

I, the undersigned applicant, certify that I have read, or have had read to me, this completed application and that I realize that any false statement or misrepresentation in this enrollment application may result in voidance of my Certificate.

If your age has been misstated in the enrollment application, we will adjust the premium to reflect the amount that should have been paid based on your correct age. If your age has been misstated in the enrollment application and, if based on your correct age this Medicare Supplement Insurance policy would not have been issued, we will refund premium paid, less the amount of any claims paid, and the Certificate will be considered never to have been issued.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment application for insurance may be guilty of a crime and may be subject to fines and confinement in prison, and it may result in denial of coverage under the group policy.

Applicant Signature: _____ Date: _____

This application is not acceptable unless completely filled out and signed. A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Please send one signed and dated copy of this enrollment application to our Home Office at P.O. Box 313, Columbia, TN 38402-0313. Retain one signed and dated copy of this enrollment application for your records.

If you would prefer to email a scanned version of the application and applicable forms, please contact our Home Office for assistance at 877-874-8323.