



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

General Information

Thank you for your interest in enrolling for Medicare Supplement Insurance policy with Farm Bureau Health Plans ("FBHP"). Please read the following guidelines carefully to assist you in completing the application.

1. To apply for this Medicare Supplement Insurance, you must:
 - a. Be enrolled as an active member in the Tennessee Farm Bureau;
 - b. Be age sixty-five (65) or over;
 - c. Be enrolled in both Medicare Parts A and B; and
 - d. Apply for coverage under the group policy and pay the required premium.
2. A Tennessee Farm Bureau membership is required for enrollment under the group policy. If you do not currently have a Tennessee Farm Bureau membership, please complete and submit a Tennessee Farm Bureau Membership Application and provide a separate check in the amount of your initial Tennessee Farm Bureau membership dues as indicated on the Tennessee Farm Bureau Membership application.
3. Please check your enrollment application for accuracy and be sure to sign your first and last name beside any corrections. Prompt return of any additional documents requested will prevent unnecessary delays in the underwriting process.
4. IF YOU HAVE CURRENT COVERAGE, DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL YOU HAVE BEEN ISSUED A CERTIFICATE OF COVERAGE (the "Certificate") BY US AND UPON REVIEW, AGREE TO ACCEPT THE PREMIUM, TERMS AND CONDITIONS OF THE NEW CERTIFICATE.
5. If approved for coverage, you will be mailed a billing statement for the initial amount due. This billed amount must be paid by the due date. Once the billed amount has been paid, each monthly billing thereafter will be by automatic draft from your bank account.
6. FBHP Medicare Supplement Insurance policies are age-rated. Your premium will be based on your current age and will be adjusted annually with each birthday. In addition, overall general premium adjustments may be necessary. You will be notified by letter 30 days in advance of any premium adjustment.
7. Your Plan Identification Card ("ID card") and Certificate should arrive within a few days of your initial billing. Please review both the ID card and the Certificate carefully, as they contain important information about your coverage. If you find that you are not satisfied with your Certificate for any reason, you may return it to us. If you send the Certificate back to us within 30 days after you receive it, we will treat the Certificate as if it had never been issued and return all of your payments, less any claims paid.

Please refer to Open Enrollment and Guaranteed Issue information on the next page.

Open Enrollment

You are eligible for open enrollment if you are applying within six (6) months of turning age sixty-five (65) or obtaining Medicare Part B, whichever occurs last. If you are in your open enrollment period, have not had a break in coverage of sixty-three (63) days or more, and at the time of application can provide proof of prior continuous creditable coverage of at least six (6) months, the pre-existing condition waiting period will be waived. If your prior continuous creditable coverage is less than six (6) months, the pre-existing condition waiting period will be reduced by the number of months prior continuous creditable coverage existed.

Guaranteed Issue

You may qualify for the guaranteed issue of Plans A, D and G if you apply within sixty-three (63) days of losing other coverage and you:

- Are in a Medicare Advantage plan (also known as Medicare Part C) and the plan is leaving the Medicare program, discontinues plans in your area, or you move out of the Medicare Advantage plan's service area;
- Are in original Medicare (Medicare Part A and Part B) and have coverage through an employer group health plan (including retiree or COBRA) or union plan that pays after Medicare pays, and the employer group health plan or union plan terminates;
- Joined a Medicare Advantage plan when you first became eligible for Medicare Part A at age sixty-five (65) and within twelve (12) months of joining, you decide you want to switch to original Medicare;
- Dropped your Medicare Supplement Insurance to join a Medicare Advantage plan for the very first time, have been in the Medicare Advantage plan less than twelve (12) months, and want to switch back to original Medicare; or
- Are age sixty-five (65) or older with Medicare and are disenrolled from Medicaid.

Documentation verifying your circumstances will be required.

Please Note:

There may be other circumstances that qualify you for the guaranteed issue provision. Please consult with our Home Office regarding your circumstances at 877-874-8323, 7 a.m. - 5 p.m., Central Time. If you are not eligible for guaranteed issue, a six (6) month pre-existing condition waiting period may apply if you are approved for coverage.



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
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Section 1 – Insured Person (Owner)

First Name		MI	Last Name	
Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> 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:	<input type="checkbox"/> No <input type="checkbox"/> Yes within the last 12 months <input type="checkbox"/> Yes more than 12 months ago
<input type="checkbox"/> Yes <input type="checkbox"/> 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



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.



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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you enrolled in Part A (Hospital) of Medicare? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are you enrolled in Part B (Medical) of Medicare?
(a) If "No," give your expected effective date _____ | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are you under age 65 and eligible for Medicare due to a disability? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Yes <input type="checkbox"/> No |



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)?

☐ Yes ☐ No

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.

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:

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



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.



FARM BUREAU HEALTH PLANS PERSONAL REPRESENTATIVE DESIGNATION INSTRUCTIONS

The following form is used to designate someone as a personal representative. Appointing a representative is completely optional and allows the designated person to contact us and receive detailed information regarding the insured's Farm Bureau Health Plans ("FBHP") coverage and claims information including protected health information. Only one insured may be listed per form.



FARM BUREAU HEALTH PLANS PERSONAL REPRESENTATIVE DESIGNATION (065)

You have the right to request that Farm Bureau Health Plans ("FBHP") give another person access to your protected health information. To do so, please complete this form along with your signature and return it to the

You may revoke this designation at any time with written notice to FBHP.

List information for the insured whose health information will be shared.

INSURED INFORMATION (REQUIRED) - PLEASE PRINT

MI:	Last Name:	
Address:		City, State, Zip:
Date of Birth:	Social Security #:	Identification #:
E-mail Address:		

List information for the person designated to have access to the above insured's health information.

PERSONAL REPRESENTATIVE - PLEASE PRINT

MI:	Last Name:	
Address:		City, State, Zip:
Telephone:	Relationship to Insured:	

Complete only if more than one representative is needed.

OPTIONAL REPRESENTATIVE - PLEASE PRINT

MI:	Last Name:	
Address:		City, State, Zip:
Telephone:	Relationship to Insured:	

Sign here if you are the INSURED listed above.

SIGNATURE (REQUIRED)

I, the insured named above, am requesting that Farm Bureau Health Plans be allowed access to my protected health information. I understand that I may revoke this designation at any time with written notice to FBHP.

Insured Signature

Date

If the insured is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation must be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must be submitted with this form.

Sign here if you are:

POWER OF ATTORNEY/CONSERVATOR

- ☐ Papers are required if not already on file.

Relationship to Insured

Date

In order to process this designation, this form must be complete and signed by the insured. Incomplete forms will not be accepted. Return this form to the FBHP Privacy Office, PO Box 313, Columbia, TN 38402-0313, or email to privacyforms@fbhp.com.

For questions, call the FBHP Privacy Office at 931-560-0041, Ext. 3115

YOU ARE ENTITLED TO A COPY OF THIS REQUEST



FARM BUREAU HEALTH PLANS PERSONAL REPRESENTATIVE DESIGNATION (O65)

You have the right to request that Farm Bureau Health Plans ("FBHP") give another person access to your protected health information. To do so, please complete this form along with your signature and return it to the FBHP Privacy Office. You may revoke this designation at any time with written notice to FBHP.

INSURED INFORMATION (REQUIRED) – PLEASE PRINT

First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Social Security #:	Identification #:
Telephone:	E-mail Address:	

PERSONAL REPRESENTATIVE – PLEASE PRINT

First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Insured:

OPTIONAL REPRESENTATIVE – PLEASE PRINT

First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Insured:

SIGNATURE (REQUIRED)

I request the person(s) named above be allowed access to my protected health information. I understand that I may revoke this designation at any time by submitting a written notice to FBHP.

Insured Signature

Date

If the insured is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation of the condition should be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must accompany this form.

Signature of Legal Representative

Relationship to Insured

Date

In order to process this designation, this form must be complete and signed by the insured. Incomplete forms will not be accepted. **Return this form to the FBHP Privacy Office, PO Box 313, Columbia, TN 38402-0313, or email to privacyforms@fbhp.com.**

**For questions, call the FBHP Privacy Office at 931-560-0041, Ext. 3115
YOU ARE ENTITLED TO A COPY OF THIS REQUEST**



Farm Bureau Health Plans
PO Box 313
Columbia, TN 38402-0313
Phone: 877-874-8323
Billing Fax: 931-560-4278
billingforms@fbhealthplans.com

Bank Draft Authorization Form

****For Medicare Supplement Members Only****

County Office or FBHP Agent Use Only

Subgroup	County	Branch
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General Information

- All requested information below is required to authorize your automatic bank draft.
- Upon completion, please submit to address, fax, or email above.
- For bank changes, the form must be received at FBHP 10 days prior to the draft effective date.
- Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.
- **Cancellation-** the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to Farm Bureau Health Plans. Coverage will remain in effect until the paid-to-date. See your contract for specific information regarding cancellations and cancellations due to death of Subscriber.

Applicant/Subscriber Information

First Name	MI	Last Name
Health Plan Subscriber ID Number		Requested Date of Change (for existing subscribers)

Banking Information Please complete or attach voided check.

Authorization Type: <input type="checkbox"/> New Applicant <input type="checkbox"/> Existing Subscriber	Requested Monthly Draft Date	<input type="checkbox"/> 1st of each month <input type="checkbox"/> 15th of each month
Account Type: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account		

☐ Check this box if the **Primary Name on Bank Account** is not the same as the **Primary Applicant** for coverage. This serves as authorization for payments to be made from the bank account entered below.

Name of Financial Institution

Address of Financial Institution

Routing Number

Account Number

Authorization

I hereby authorize Farm Bureau Health Plans to initiate debit entries from the account indicated above for the monthly payment of health coverage. The depository named above is authorized to debit my account. I acknowledge I am authorized to sign this agreement on behalf of all covered individuals and signatories to the account. I understand I have the right to revoke this authorization by notifying Farm Bureau Health Plans in writing at least ten (10) days prior to the time payment is due. I further agree that should a debit be dishonored, whether with or without a cause, and whether intentionally or inadvertently, Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Applicant/Subscriber Printed Name

Payor Printed Name

Applicant/Subscriber Signature

Today's Date

Payor Signature

Today's Date

A scanned, imaged, or photocopied version of this completely executed form will have the same force and effect as the original document.



**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

Home Office: P.O. Box 313, Columbia, TN 38402-0313, 1-877-874-8323

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your enrollment application, you intend to terminate existing Medicare Supplement or Medicare Advantage Insurance and replace it with a Certificate to be issued by Farm Bureau Health Plans. Your new Certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the Certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement Insurance is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage Insurance. You should evaluate the need for other accident and sickness coverage you have that may duplicate this Certificate.

STATEMENT TO APPLICANT BY INSURANCE COMPANY

We have reviewed your current medical or health insurance coverage. To the best of our knowledge, this Medicare Supplement Insurance will not duplicate your existing Medicare Supplement Insurance or, if applicable, Medicare Advantage Insurance because you intend to terminate your existing Medicare Supplement Insurance or leave your Medicare Advantage Insurance. The replacement Certificate is being purchased for the following reasons (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain the reason for disenrollment:
- ☐ Other (please specify): _____

(1) State law provides that your replacement Certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new Certificate to the extent such time was spent (depleted) under the original policy.

(2) If you still wish to terminate your present Policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the enrollment application concerning your medical and health history. Failure to include all material medical information on an enrollment application may provide a basis for the company to deny any future claims and to refund your premium as though your Certificate had never been in force. After the enrollment application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new Certificate and are sure that you want to keep it.

Applicant Signature _____

Date _____



Medicare Supplement Insurance Application Checklist

The Farm Bureau Health Plans ("FBHP") Medicare Supplement Insurance enrollment application is not acceptable unless completely filled out and signed and all applicable documents are submitted. The following checklist has been provided to assist you with the accuracy and completion of your enrollment application and the application process.

- ☐ **Section 1 – Insured Person (Owner)**
 - Complete with current information for you or the person for whom you are applying.
- ☐ **Section 2 – Medicare Supplement Insurance Plan Selection**
 - Select one Medicare Supplement Plan of your choice.
- ☐ **Section 3 – Medicare Card Information**
 - Complete the information exactly as it appears on your Medicare Card. You must be enrolled in Medicare Part A and Part B to be eligible to apply.
- ☐ **Section 4 – Important Coverage Information**
 - Please read this section carefully.
- ☐ **Section 5 – General Questions**
 - Answer all questions regarding about your Medicare eligibility.
- ☐ **Section 6 – Other Coverage Information**
 - Answer all questions and provide applicable information regarding other coverage you have.
- ☐ **Section 7 – Medical Questions**
 - Answer all questions "Yes" or "No" and provide all information applicable to these questions.
 - Please complete any prescription drugs you are currently taking.
- ☐ **Section 8 – Acknowledgements and Agreements**
 - Please read carefully
 - Sign and date the application
- ☐ **FBHP Bank Draft Authorization Form**
 - Complete the FBHP Bank Draft Authorization including payor information
- ☐ **Tennessee Farm Bureau Membership**
 - A Tennessee Farm Bureau Membership is required. Complete the Tennessee Farm Bureau Membership Application and Agreement if you are not currently a member.
- ☐ **Return to Farm Bureau Health Plans**
 - Mail (completed documents) to P.O. Box 313, Columbia, TN 38402-0313 – OR – Email to appsforms@fbhp.com

Farm Bureau Health Plans toll-free number is 877-874-8323, 7:00 a.m. - 5:00 p.m., CST

Don't forget!

Tennessee Farm Bureau members have access to a wealth of special offers and discounts at many regional destinations and retailers. Explore your member benefits and start saving today at [\[https://www.tnfarmbureau.org/membersavings.\]](https://www.tnfarmbureau.org/membersavings)

REMINDER: Retain one signed and dated copy of the FBHP Medicare Supplement Insurance enrollment application.

Your choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our uses and disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and**

the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Your information. Your rights. Our responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will not use or further disclose your medical information for any purpose if we do not issue you health coverage, except as required by law.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

This notice applies to the privacy practices of the following affiliated covered entities that may share your Protected Health Information as needed for the purposes of treatment, payment, and health care operations. Tennessee Rural Health Improvement Association ("FBHP"), TRH Health Insurance Company, RH Group Services, Inc., Members Health Insurance Company, Farm Bureau Health Plans of Michigan, Indiana Farm Bureau Health Plans, Kansas Farm Bureau Health Plans, South Dakota Farm Bureau Health Plans, and Texas Farm Bureau Health Plans.

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