FARM BUREAU HEALTH PLANS
DENTAL APPLICATION

PLEASE PRINT USING BLACK INK

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

Section 1 – Primary Applicant Information

First Name	MI	Last Name	
Date of Birth	Age	Gender	Social Security No.
		☐Male ☐Female	
Marital Status		I am a united States Citizen or Legal Resident	
☐Single ☐Married		☐Yes ☐No	
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)			

How did you hear about FBHP?
☐ Internet ☐ TV ☐ Phone Book ☐ Radio ☐ Mail Ad ☐ Billboard ☐ TN Farm Bureau ☐ Family/Friend

Section 2 – Application Information

☐ Yes ☐ No	Are you an existing TN Farm Bureau member? If "No", please submit a TN Farm Bureau Membership Application and Agreement. If "Yes", please complete the following information: TN Farm Bureau membership is in the name of: _____ TN Farm Bureau Membership Number: _____
☐ Yes ☐ No	Are you or anyone for whom you are applying currently covered by another FBHP Dental plan? If "Yes," please provide the following information: Name of Insured _____ Relationship of Insured_____ ID Number_____

☐ New Application for Coverage	☐ Reapplication – Current FBHP member re-applying for new coverage	☐ Transfer – Current FBHP member transferring from other coverage	Add Dependent to: ☐ Existing Family Coverage Existing Individual Coverage ☐ (Changing to 2-person or family coverage)

Current FBHP ID Number (if making a change to your current FBHP Coverage):

Section 3 – Coverage Options

☐ FBHP Dental Care (Copay) Individual Coverage	☐ FBHP Dental Care (Copay) 2-Person Coverage	☐ FBHP Dental Care (Copay) Family Coverage

Please note: For Dental Care (Copay) Individual Coverage only, Page 2 is not required for a complete application.

Farm Bureau HEALTH PLANS Tennessee

Primary Applicant First Name _____ MI _____ Last Name _____

Section 4 – Spouse/Dependent Information

Please complete only if your Spouse and/or dependent children are applying for coverage.

SPOUSE First Name		MI	Last Name
Date of Birth	Age	Gender ☐Male ☐Female	Social Security No.
Relationship to Applicant			I am a United States Citizen or Legal Resident ☐ Yes ☐ No
DEPENDENT 1 First Name		MI	Last Name
Date of Birth	Age	Gender ☐Male ☐Female	Social Security No.
Relationship to Applicant			I am a United States Citizen or Legal Resident ☐ Yes ☐ No
DEPENDENT 2 First Name		MI	Last Name
Date of Birth	Age	Gender ☐Male ☐Female	Social Security No.
Relationship to Applicant			I am a United States Citizen or Legal Resident ☐ Yes ☐ No
DEPENDENT 3 First Name		MI	Last Name
Date of Birth	Age	Gender ☐Male ☐Female	Social Security No.
Relationship to Applicant			I am a United States Citizen or Legal Resident ☐ Yes ☐ No
DEPENDENT 4 First Name		MI	Last Name
Date of Birth	Age	Gender	Social Security No.
Relationship to Applicant			I am a United States Citizen or Legal Resident ☐ Yes ☐ No

☐ Yes ☐ No	1. Are all children for whom you are applying under the age of 26, and your (Please select all that apply): ☐ Biological children ☐ Adopted children ☐ Step-children ☐ Children placed with you in anticipation of adoption ☐ Children for whom you are legal guardian If "No," please explain _____ If there are court documents establishing guardianship or custody for any children for whom you are applying, please submit a complete copy of the final documents including but not limited to a court order establishing guardianship/custody.

Farm Bureau HEALTH PLANS Tennessee

Primary Applicant First Name | MI | Last Name

Section 5 – Acknowledgements and Agreements

Please read carefully and sign below

If approved for coverage, Tennessee Rural Health Improvement Association ("Farm Bureau Health Plans" or "FBHP") will mail you a billing statement for the initial amount due. This billed amount will need to be paid by the due date. Once the billed amount has been paid, the automatic withdrawal from your bank account will begin on or after the 1st of the following month.

Your FBHP Plan ID card(s) and contract will arrive shortly after the billing. Please review both the Plan ID card and the contract carefully. You will have 30 days from the date you receive your contract to decide if you want to continue the coverage.

I understand and acknowledge that any coverage which may be issued:

- Will be effective, subject to all the terms and conditions of the contract, on the date indicated with the issuance of the plan ID card;
- Shall be binding only if each statement included on the application is complete and accurate; and
- May be transferable to another coverage classification within the FBHP program.

I understand the information in this application and any information obtained with this authorization will be used by FBHP to determine eligibility for coverage and that coverage and rates will be affected by this information. Rates resulting from an offer of coverage made more than 30 days in advance of the effective date could be subject to change.

If I am not already a member, I hereby make application for membership in the Tennessee Farm Bureau/FBHP. I understand this membership entitles me to apply for the services offered by FBHP and the Tennessee Farm Bureau.

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete for myself, my spouse and all dependent children for whom I am applying. I understand it is a crime to knowingly provide false, incomplete or misleading information to FBHP for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of coverage.

FBHP reserves the right to request proof of continuing dependent eligibility at any time. In the event dependent eligibility cannot be determined based on the answers submitted on the application, additional information may be requested.

Acknowledgement for Individual Adult or Family Coverage

All individuals for whom application is made who are 18 years of age or older must sign and date the application, acknowledging their understanding of and agreement to the conditions listed above.

Applicant Signature | **Today's Date** | **Spouse Signature** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Acknowledgement for Child Coverage (Under age 18)

I declare the foregoing statements provided by me in this application in its entirety are true, correct and complete for the child for whom I am applying. I understand that if coverage is issued, I am the only person allowed to sign for changes to or cancellation of this coverage.

Signature of Subscriber Parent, Step-Parent or Legal Guardian | **Relationship** | **Today's Date**

Print Name of Subscriber Parent, Step-Parent or Legal Guardian | **Social Security Number**

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete for the child for whom application is made. I understand that if coverage is issued, I cannot sign for changes to or cancellation of this coverage. I understand as parent or legal guardian of the child, I may, depending upon the age of the child, have the right to obtain information about this child's application and coverage if issued.

Signature of Non- Subscriber Parent, Step-Parent or Legal Guardian | **Relationship** | **Today's Date**

Print Name of Non-Subscriber Parent, Step-Parent or Legal Guardian

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

Farm Bureau Health Plans is a taxable, not-for-profit, membership organization which promotes health care for Tennesseans. Members can learn more about the programs and services offered by Farm Bureau Health Plans through their local Tennessee Farm Bureau office.

FARM BUREAU HEALTH PLANS
DENTAL APPLICATION CHECKLIST

☐ Section 1 – Primary Applicant Information

- Complete with current information for you or the child for whom you are applying.

☐ Section 2 – Application Information

- Complete the Tennessee Farm Bureau Membership and coverage information. Select the type of application.

☐ Section 3 – Coverage Options

- Choose the plan type that best fits your needs.

☐ Section 4 - Spouse/Dependent Information

- Complete with current information and answer all questions regarding your spouse and all dependent children for whom you are applying (if applicable).

☐ Section 5 – Acknowledgements and Agreements

- Read and sign the appropriate area to acknowledge your understanding. If applying for individual adult coverage or family coverage, complete the Acknowledgement for Individual Adult or Family Coverage box. If applying for individual child coverage, complete the Acknowledgement for Child Coverage (Under Age 18) box.
- Please thoroughly review and sign your full name beside any changes or mistakes made on the application (even if white-out is used).
- Check the date that the application is signed. We cannot accept an application more than 30 days old.

☐ FBHP Bank Draft Authorization Form

- Complete the FBHP Bank Draft Authorization (including payor information).

☐ Tennessee Farm Bureau Membership

- Complete the Farm Bureau Membership Application and Agreement form with EFT Authorization if you are not currently a member.

☐ Return to Farm Bureau Health Plans

- Mail (completed FBHP application, Bank Draft Authorization Form, Farm Bureau Membership Application with EFT Authorization, if applicable) to P.O. Box 313, Columbia, TN 38402-0313, or deliver to your local Farm Bureau office. Visit fbhealthplans.com to locate an office near you.

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

Don't forget!

Your Farm Bureau membership means you have access to an array of services -- including automobile, homeowners and life insurance products, and discounts for security systems, cellular phone service and hotels.

Bank Draft Authorization Form

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

County Office or FBHP Agent Use Only

Subgroup	County Office	Branch

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 by the 20th of the month to be effective the first of the following month.
- 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

Requested Date of Change	Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number

Banking Information

Authorization Type ☐ New Applicant ☐ Existing Subscriber	Requested Date of Change (for existing Subscribers)

Please complete or attach voided check.

Account Type: ☐ Checking Account ☐ Savings Account

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 below for the monthly payment of health and/or dental coverage. The depository named below 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 **(Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)**		**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.