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

Alternative Plan Selection | Transfer | Change Form

Upon completion, please submit to address, fax or email above.

County:	**ID Number:**

Section 1 Subscriber Information

First Name	MI	Last Name
Date of Birth / Age	Gender ☐ Male ☐ Female	Social Security Number
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____		Date of Marriage/Divorce
Mailing Address If this is a new address, check this box: ☐		
City / State / Zip		TN Farm Bureau Membership Number
Phone Number	Email Address (by providing your email address, you agree to receive electronic communications from FBHP)	

Section 2 Reason for Change

☐ **Alternative Plan Option** ☐ **Transfer Option**
- List the plan/deductible below.
- List any previously approved dependents you wish to have on your plan in Section

Plan Name: **Deductible:** ☐ **Individual Coverage** ☐ **Family Coverage**

By signing the form below, I understand and acknowledge:
- This acceptance form shall supplement my previously submitted Farm Bureau Health Plans Traditional Membership Application, and all terms of such are incorporated within.
- FBHP has offered and I am selecting the plan listed above as health care coverage for the member listed in Section 1 and any dependents in Section 3.
- The offer is time sensitive and must be returned to FBHP within 30 days of the date of the offer letter or the offer of coverage will be revoked.
- I have fully read, understand, and agree to all terms and conditions and hereby accept the designated plan listed above for healthcare coverage.

☐ **Name/County Change**	Change Name/County to	Former Name/County
☐ **Request Plan Effective Date Change**		
☐ **Change my Coverage**	(NOTE: Once you change coverage, you will not be able to go back to the previous plan unless you re-apply) Plan Name: Deductible:	
☐ **Dependent Change**	Maternity Benefits | Individual Coverage: No maternity benefits provided, unless Enhanced Choice Plan. Family Coverage: Maternity benefits available after coverage has been in effect for nine consecutive months. Additional documentation may be required if adding or deleting spouse/dependent(s). List date of marriage or divorce if applicable.	
	☐ Change my coverage from individual to family	☐ Change my coverage from family to individual
	☐ Add the following spouse/dependent(s)	☐ Delete the following spouse/dependent(s)

Section 3 Dependents (For Accepting Underwriting Option or Dependent Change Only)

DEPENDENT 1 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth/Death	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 2 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth/Death	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 3 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth/Death	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____		Date of Marriage/Divorce	Relationship to Subscriber

Section 4 Acknowledgement

It is a crime to knowingly provide false, incomplete information for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. A scanned, image or photocopied version of this completely executed form will have the same force and effect as the original document.

Subscriber Signature **Today's Date**

Bank Draft Authorization Form

For Under 65 and Dental Plans Only

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County Office or FBHP Agent Use Only

Subgroup	County	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.
- **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	Dental Plan Subscriber ID Number

Banking Information

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

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**

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