FARM BUREAU HEALTH PLANS DENTAL APPLICATION

Section 1 – Primary Applicant Information

Primary Applicant First Name		MI	Last Name	**FOR OFFICE USE ONLY**
Date of Birth	Age	Gender ☐Male ☐Female	Social Security No.	Sub Group
Mailing Address				County
City		State	Zip Code	Effective Date
Phone No. ( ) _____ - _____ May we leave a message? ☐ Yes ☐ No		Alternate No. ( ) _____ - _____ May we leave a message? ☐ Yes ☐ No		ID Number
Email Address				

Marital Status (Optional): ☐ Single ☐ Married ☐ Widowed ☐ Divorced Date of Marriage/ Divorce_____

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 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_____
☐ 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: _____

Section 3 – Coverage Options

☐**FBHP Dental Care (Copay) Individual Coverage**	☐ New Application for Coverage	☐ Add ad Dependent to Existing Family Coverage
☐**FBHP Dental Care (Copay) 2-Person Coverage**	☐ Transfer From Other FBHP Coverage	☐ Add a Dependent to Existing Individual Coverage (Change to 2-Person or Family Coverage)
☐**FBHP Dental Care (Copay) Family Coverage**		

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.
Dependent 1 First Name		MI	Last Name	
Date of Birth	Age	Gender ☐Male ☐Female		Social Security No.
Dependent 2 First Name		MI	Last Name	
Date of Birth	Age	Gender ☐Male ☐Female		Social Security No.
Dependent 3 First Name		MI	Last Name	
Date of Birth	Age	Gender ☐Male ☐Female		Social Security 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 _____
☐ Yes ☐ No	2. Are there documents establishing adoption, anticipation of adoption or guardianship for any children for whom you are applying? If "Yes," please submit a complete copy of the final documents including but not limited to the Final Order of Adoption, documentation demonstrating the child has been placed with you in anticipation of adoption or a court order establishing guardianship.

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 should arrive within a few days of 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.

FBHP is entitled to rely on the statements made on this application which are complete and correct.

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 true; and
- May be transferable to another coverage classification within the FBHP program.

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 the eligibility of each person for whom application is made, to give to FBHP or its affiliates, all such information. I (or my personal representative) may request a copy of this authorization.

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 underwriting determination 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 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)	**Today's Date**	**Dependent Signature (age 18 and older)**	**Today's Date**
Dependent Signature (age 18 and older)	**Today's Date**	**Dependent Signature (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 coverage information, Tennessee Farm Bureau Membership section and select the type of application.

☐ Section 3 – Coverage Options
- Complete the coverage information

☐ 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).

☐ TN Farm Bureau Membership
- Complete the Farm Bureau Membership Application and Agreement form with EFT Agreement 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 Agreement, 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.

FBHP's toll-free number is 1-877-874-8323, 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.

FARM BUREAU HEALTH PLANS
BANK DRAFT AUTHORIZATION FORM

The following must be completed to authorize your automatic bank draft after you pay the initial paper invoice. If you are changing bank account information, this form must be received in our office ten (10) days prior to the next scheduled draft date.

1. **Signature of Applicant/Subscriber** (Required) – Subscriber must sign and date that he/she agrees to the terms and conditions as set forth in the Bank Draft Authorization. The Bank Draft Authorization must be signed by parent or legal guardian if member is under age 19.

2. **Signature of Payor** (Required) and **Print Payor Name** (Required) – Payor (owner/signatory of account) must sign and print name.

3. **Applicant/Subscriber Name** (Print) – Subscriber must print name.

4. **Identification Number** – Subscriber's Farm Bureau Health Plans identification number must be included.

5. Check **"Health," "Dental,"** and/or **"Prescription"** box(es) that apply.

6. Check **"Bank Change"** box and write in effective date of change.

7. Check **Account Type – "Checking" or "Savings".**

8. Mail completed form to **Farm Bureau Health Plans, P.O. Box 313, Columbia, TN 38402- 0313**,
   -OR-
   Fax completed form to **Farm Bureau Health Plans, (931) 560-4278, Attention: Billing Department**.

9. Verify receipt of mailed or faxed form by calling (931) 560-0041 or toll free (877) 874-8323 and request to speak to a Billing Department representative.

Please note: Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.

FARM BUREAU HEALTH PLANS
BANK DRAFT AUTHORIZATION FORM

☐ **Health** ☐ **Dental** ☐ **Prescription** **(Check all that apply)**

I hereby authorize Farm Bureau Health Plans to initiate debit entries from the account indicated below for the monthly payment of health, dental, or prescription 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 further 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 cause and whether intentionally or inadvertently, Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

_____ _____

Print Applicant/Subscriber Name (Required) **Print Payor Name (Required)**

_____ _____

Signature of Applicant/Subscriber (Required) **Signature of Payor (Required)**
(Must be signed by parent, step-parent or legal guardian of minor applicant)

_____ _____ _____

Date **County** **Subgroup**

_____ _____ _____

ID Number – Health **ID Number – Dental** **ID Number – Prescription**

☐ Quarterly to Bank Draft _____ (effective date)

☐ New Application

☐ Transfer

☐ Bank Change _____ (effective date)

Account Type
☐ Checking ☐ Savings

Please Complete (or attach a voided check)

_____

Name and Address of Financial Institution

_____ _____

Routing Number **Account Number**

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.