



Change 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	Branch

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

Subscriber Information			
First Name	MI	Last Name	
Date of Birth	Subscriber ID Number	Current TFB Membership ID Number	
Mailing Address			
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.)			

Changes

I wish to make the following changes:			
<input type="checkbox"/> Name Change	Change Name to	Former Name	
<input type="checkbox"/> Address Change	Mailing Address		
	City	County	State Zip Code
<input type="checkbox"/> County Change	New County/Branch	Former County/Branch	
<input type="checkbox"/> Plan Change	Change Coverage to (NOTE: Once you change coverage, you will not be able to go back to the previous plan unless you re-apply)		
<input type="checkbox"/> Dependent Change	<input type="checkbox"/> Change my coverage from individual to family		<input type="checkbox"/> Change my coverage from family to individual
	<input type="checkbox"/> Add the following spouse/dependent(s)		<input type="checkbox"/> Delete the following spouse/dependent(s)
Maternity Benefits <i>Individual Coverage:</i> No maternity benefits provided. <i>Family Coverage:</i> Maternity benefits available after coverage has been in effect for nine consecutive months. Documentation If adding or deleting spouse/dependent(s), list date of marriage or divorce. Additional documentation may be required.			

DEPENDENT 1 First Name	MI	Last Name	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of Marriage/Divorce
DEPENDENT 2 First Name	MI	Last Name	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of Marriage/Divorce
DEPENDENT 3 First Name	MI	Last Name	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of Marriage/Divorce

Authorization	
Subscriber Signature _____	Today's Date _____
<i>A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.</i>	