FARM BUREAU HEALTH PLANS
SHORT TERM CARE APPLICATION

County Office or FBHP Agent Use Only				
Subgroup	County Office	FBHP Agent	County Received Date	Date Applicant Received Contract

Section 1 - Primary Applicant Information

First Name		MI	Last Name
Date of Birth	Age as of Effective Date	Gender ☐ Male ☐ Female	Social Security No.
Marital Status: ☐ Single ☐ Married			I am a united States Citizen or Legal Resident ☐ 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 Farm Bureau Health Plans?

☐ Internet ☐ Billboard ☐ Phone Book ☐ TN Farm Bureau ☐ Mail Ad ☐ Radio ☐ Family/Friend ☐ TV

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 in the name of: _____ TN Farm Bureau Membership number: _____

Requested Effective Date	☐ Payment submitted by Bank Draft	☐ Payment submitted by check.
_____ /_____ /_____	Payment amount expected to draft: $_____	Payment amount enclosed: $_____ Submitted check number: _____ Name on check submitted: _____

Section 3 – Coverage Options

☐ **Short Term Care** **60 Days | $1,000 Deductible**	☐ **Short Term Care** **90 Days | $1,000 Deductible**	☐ **Short Term Care** **180 Days | $1,000 Deductible**
☐ Individual Coverage	☐ Individual Coverage	☐ Individual Coverage
☐ Family Coverage	☐ Family Coverage	☐ Family Coverage
☐ Child Only Coverage (ages 3-17)	☐ Child Only Coverage (ages 3-17)	☐ Child Only Coverage (ages 3-17)

Please note: For Short Term Care Individual Coverage only, Page 2 is not required for a complete application.

Farm Bureau HEALTH PLANS Tennessee

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 ☐ Male ☐ Female	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

First Name | MI | Last Name

Section 5 – Acknowledgements and Agreements

Coverage Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

I hereby declare, as of the effective date of this coverage, myself, my spouse, and any children for whom I am applying:

- Do not have another health care coverage or health insurance policy in force
- Are not currently covered by Medicare due to a disability
- Are not currently confined to a health care facility
- Are not currently an expectant parent (Short Term Care plans do not offer maternity benefits)
- Are not younger than age 3 or older than age 64

Pre-Existing Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

Short Term Care Plans contain a pre-existing condition waiting period for any conditions that were in existence prior to the coverage's effective date for anyone on the contract.

- A pre-existing condition is defined in the contract as: "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."
- The pre-existing condition waiting period applies regardless of any previous or current coverage. This is not an application designed to accommodate the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA); therefore, portable/creditable coverage does not apply and no portion of your applicable pre-existing condition waiting period will be waived.
- Any and all claims that are filed during this pre-existing condition waiting period will be reviewed by FBHP to verify they are not related to a pre-existing condition.

Contract Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

I have received a copy of the contract for the FBHP Short Term Care plan selected and I have 10 days from the date of receipt of the contract to decide if I want to continue the coverage. Should I choose not to continue the coverage, to qualify for a refund of premiums paid, I must cancel the coverage within 10 days from the date of receipt of the contract.

HIPAA Acknowledgement: Please read carefully and initial in the space provided

I understand and acknowledge — **Initial here:**

This is not an application designed to accommodate the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA); therefore, portable/creditable coverage does not apply and no portion of my applicable pre-existing condition waiting period will be waived. In applying for this coverage, I understand and acknowledge that other health insurance issuers make available to individuals other health coverage plans which do not require medical underwriting and do not apply pre-existing condition limitations for individuals who have met certain prior creditable coverage requirements. I hereby acknowledge that although such portable coverage may be available to me/us, based on rates or other reasons, I have declined to apply for such coverage at this time.

Eligibility Acknowledgement: Please read carefully and initial in the space provided

I understand and acknowledge — **Initial here:**

I must immediately notify FBHP when there is any change in the information submitted on this application concerning the eligibility for coverage of any dependent, including my spouse.

Farm Bureau HEALTH PLANS Tennessee

First Name | MI | Last Name

Section 5 - Acknowledgement and Agreements (Continued)

IMPORTANT: Your FBHP Plan identification card(s) should arrive within a few days of processing the application. Please review the contract carefully, as it contains important information. You will have 10 days from the date you receive your contract to decide if you want to continue the coverage. FBHP is entitled to rely solely on the statements made on this application which are complete and correct.

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

- Is limited
- Will be effective, subject to all the terms and conditions of the contract, on the date indicated with the issuance of the identification card;
- Shall be binding only if each statement included on the application is complete and true; and
- Is not transferable to another coverage classification within the FBHP program.
- Short Term Care plans are not continuous and end after the plan's designated term. Any subsequent coverage is considered new coverage with a new effective date and ID number. Any illnesses and/or injuries occurring during any previous Short Term Care plan will be considered a pre-existing condition on the next Short Term Care plan.

I hereby 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 for the purposes of underwriting, premium determination, and/or claims administration. 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.

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.

Acknowledgement for Individual Adult or Family Coverage

All individuals for who application is made who are 18 years of age or older must sign and date the application, acknowledging their understanding of an 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**

Acknowledgement for Child Coverage (Age 17 and Under)

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 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 | **Printed Name of Subscriber Parent, Step-Parent or Legal Guardian**

Relationship | **Social Security Number** | **Today's Date**

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 | **Printed Name of Non-Subscriber Parent, Step-Parent or Legal Guardian** | **Relationship** | **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.

Farm Bureau Health Plans is a taxable, not-for-profit, membership organization which promotes health care for the rural people of Tennessee. 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
SHORT TERM CARE 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

- Provide your Tennessee Farm Bureau Membership information (required for enrollment).
- Provide the requested effective date of coverage (if you currently have a Short Term Care plan in place, this date will be the day after the termination date of your current Short Term Care plan).
- Select the appropriate payment method and complete the details for the payment (payment is required at the time of application submission.

Section 3 - Coverage Options

- Choose one plan with corresponding coverage for individual, family or child.

Section 4 – Spouse / Dependent Information

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

Section 5 – Acknowledgements and Agreements

- Read and initial each area as requested 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 Child Only Coverage, complete the Acknowledgement for Child Coverage (Age 17 and Under) 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.

Bank Draft Authorization Form

- Complete the FBHP Bank Draft Authorization if not paying by check.

TN Farm Bureau Membership

- A TN Farm Bureau Membership is required. 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, and Farm Bureau Membership Application with EFT Agreement, if applicable) to P.O. Box 313, Columbia, TN 38402-0313, email to customerservice@fbhealthplans.com or deliver to your local Farm Bureau office. Go to fbhealthplans.com to locate an office near you.

FBHP's 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.

SHORT TERM CARE
BANK DRAFT AUTHORIZATION

I hereby authorize Farm Bureau Health Plans to initiate a **one-time debit** entry from the account indicated below for the payment of health 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 this **one-time draft** will occur within 10 business days of receipt of Bank Draft Authorization Form. I further agree that should the **one-time 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)
(Must be signed by parent, step-parent or legal guardian of minor applicant)

Signature of Payor (Required)

Date: _____

Account Type - ☐ Checking ☐ Savings

PLEASE COMPLETE (or attach voided check)

Name and Address of Financial Institution

Routing Number

Account Number

Cancellation - See your contract for specific information regarding cancellations.

For internal use only:

ID Number-Health **County** **Subgroup**