Farm Bureau Health Plans
P.O. Box 313, Columbia, TN 38402-0313
877-874-8323 7:00 a.m. to 5:00 p.m. CST
fbhealthplans.com

Thank you for your interest in a Farm Bureau Health Plans Short Term Care Plan

General Information – Please Read Carefully

- Completing the Application
  - Please sign, date and initial the application (where applicable).
  - If applicant is under the age of 18, the parent or legal guardian must sign the application.
  - Individual Short Term Care plans are available for primary applicant ages 3-64 (no dependents). Family Short Term Care Plans are available to primary applicants ages 18-64 (dependent ages 0-64).
  - If you are a foreign national or an exchange student and do not have a Social Security number, we can still accept a Short Term Care application. You must have a valid Tennessee address and provide documentation showing you are in the country legally, i.e., work visa, green card, etc.
- Membership
  - A Tennessee Farm Bureau/Farm Bureau Health Plans membership is required. Please complete a Tennessee Farm Bureau Membership Application and Agreement with EFT Agreement if you are not currently a member.
- Effective Date
  - You may choose for this coverage to be effective no earlier than one (1) day after your application is submitted to the county office, one (1) day after the postmark date if your application is mailed directly to Farm Bureau Health Plans or any future date not more than 30 days from the date the application was signed.
- Payment
  - Farm Bureau Health Plans Short Term Care plans are age-rated.
  - Payment is required at time application is submitted. Please complete the Short Term Care Bank Draft Authorization Form - OR - check payable to Farm Bureau Health Plans for the entire amount due for the coverage option you choose.
- Coverage Information
  - Short Term Care plans do not provide maternity benefits.
  - Short Term Care plans do not provide coverage for pre-existing conditions.
    - 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 service; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."
    - The pre-existing condition exclusion applies regardless of any prior or current coverage. Any claims filed may be reviewed to verify they are not related to a pre-existing condition.
  - 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.
  - When this Short Term Care plan expires, you can apply for another Short Term Care plan by completing a new application. Any coverage issued will not be a continuation of coverage. Such coverage will be new coverage with a new effective date and a new ID number. Coverage from the first Short Term Care plan will not carry over.
  - The applicant cannot transfer from a Short Term Care plan to Farm Bureau Health Plans coverage.
  - A person/child cannot apply for Farm Bureau Health Plans Short Term Care if:
    - The person(s) to be covered has a health insurance policy in force;
    - The person(s) to be covered are currently covered by Medicare due to a disability;
    - The person(s) to be covered is currently confined to a health care facility;
    - The person(s) to be covered is currently an expectant parent;
    - The person(s) to be covered is age 65 or older; or
    - The person(s) to be covered is under age 3 (child only application).

Farm Bureau Health Plans Short Term Care Application

Section 1 - Primary Applicant Information

First Name	MI	Last Name	FOR COUNTY OFFICE/AGENT USE ONLY
			Subgroup

Date of Birth	Age as of Effective Date	Gender ☐ Male ☐ Female	Social Security No.	County

Mailing Address	County Received Date

City	State	Zip Code	Date Applicant Received Contract

Phone No. ( ) _____ - _____ May we leave a message? ☐ Yes ☐ No	Alternate No. ( ) _____ - _____ May we leave a message? ☐ Yes ☐ No	FOR HOME OFFICE USE ONLY ID Number
Email Address (By providing your email address, you agree to receive electronic communications from Farm Bureau Health Plans.)		Effective Date
Marital Status (Optional): ☐ Single ☐ Married ☐ Widowed ☐ Divorced Date of Marriage/Divorce: _____		Class ID
How did you hear about Farm Bureau Health Plans? ☐ Internet ☐ Billboard ☐ Phone Book ☐ TN Farm Bureau ☐ Mail Ad ☐ Radio ☐ Family/Friend ☐ TV		Plan ID

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: _____

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

Requested Effective Date	Payment Information	Payment amount enclosed or expected to draft:
_____/_____/_____	☐ Payment submitted by Bank Draft Authorization Form ☐ Payment submitted by check. Check number: _____ Name on check submitted: _____	$_____

Section 3 – Spouse / Dependent Information

SPOUSE First Name			MI	Last Name

Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	Relationship to Applicant

DEPENDENT 1 First Name			MI	Last Name

Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	Relationship to Applicant

DEPENDENT 2 First Name			MI	Last Name

Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	Relationship to Applicant

DEPENDENT 3 First Name			MI	Last Name

Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	Relationship to Applicant

DEPENDENT 4 First Name			MI	Last Name

Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	Relationship to Applicant

Primary Applicant First Name	MI	Last Name

Section 3 - Continued

☐ Yes ☐ No	Are all children for whom you are applying under age 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	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 court order establishing guardianship.

Farm Bureau Health Plans reserves the right to request proof of continuing 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.

Section 4 – Acknowledgements

Please Read Carefully and Initial/Sign Below

Tennessee Rural Health Improvement Association ("Farm Bureau Health Plans" or "FBHP") is entitled to rely on the statements made on this application which are complete and correct.

I understand and acknowledge that I must:
Immediately notify FBHP when there is any change in the information submitted on this application concerning the eligibility for coverage of any individual for whom I am applying.
(Please initial here_____)

I hereby declare that myself, my spouse, and any children for whom I am applying:
- Do not have any other health care coverage or insurance as of the effective date of this coverage;
- Are not expectant parents; and
- As of this time, are not confined to or in any health care facility for any reason.

I understand and acknowledge that any coverage which may be issued to me:
- 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 in this application is complete and true; and
- Short Term Care plans are not continuous and end after the plan's designated term. Any subsequent coverage is considered new coverage. 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 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 applying for this coverage, to give to FBHP or its affiliates, all such information. I (or my personal representative) may request a copy of this authorization.

I understand and acknowledge this Short Term Care plan:
- Is limited;
- Is not transferable to another FBHP coverage; and
- Does not provide benefits for any pre-existing condition during the length of this coverage.

(Please 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.

(Please initial here_____)

I understand and acknowledge 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.

(Please initial here_____)

I declare that all 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 for coverage.

I understand it is a crime to knowingly provide false, incomplete or misleading information to FBHP or the Administrator for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

_____	_____	_____	_____
Applicant Signature	Today's Date	Spouses Signature	Today's Date
_____		_____	_____
Signature of Subscriber Parent, Step-Parent or Legal Guardian		Relationship	Today's Date

Farm Bureau Health Plans
Short Term Care
Bank Draft Authorization Form

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 a 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**