FARM BUREAU HEALTH PLANS
APPLICATION FOR CHANGES TO GRANDFATHERED PLANS

PLEASE PRINT USING BLACK INK

Primary Applicant Information

First Name	MI	Last Name	Phone No. ( ) _____-_____ May we leave a message? ☐ Yes ☐ No
Mailing Address			Alternate No. ( ) _____-_____ May we leave a message? ☐ Yes ☐ No
City	State	Zip Code	Email Address (if applicable):

Date of Birth – –	Age	☐ Male ☐ Female	Marital Status (Optional) ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Date of Marriage/Divorce – –	Social Security No. – –

Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (MM/YY): _____	Height	Weight	Primary Care Physician:
TN Farm Bureau membership is in the name of:	TN Farm Bureau membership number:		

OFFICE USE ONLY

Sub Group	County

Effective Date

ID Number

Rating Action:

Person **Rider(s) #**

1. _____
2. _____
3. _____
4. _____

Person(s) Excluded:

1. _____
2. _____

Section 2 Other Insurance Information

Have you or anyone for whom you are applying been covered by or are you or anyone for whom you are applying currently covered by another FBHP, TRHH, TRH or UMR policy? ☐ Yes ☐ No If "Yes," please provide the following:

Name of Insured	Relationship to Insured ☐ Self ☐ Parent ☐ Spouse ☐ Step-Parent	ID/Policy No.	Group No.

Section 3 Application Type

☐ Add a Dependent to Existing Family Coverage ☐ Add a Dependent to Existing Individual Coverage and Change to Family

☐ Transfer From Other FBHP or TRHH Coverage. **Current ID Number:** _____

Section 4 Coverage Options

☐ **Complete Care - Deductible: $1500**
☐ **Individual** *(No maternity benefits)* ☐ **Family** *(Maternity benefits after a member's coverage has been in effect for 9 consecutive months.)*

☐ **Major Medical - Deductible: $5000**
☐ **Individual** *(No maternity benefits)* ☐ **Family** *(Maternity benefits after a member's coverage has been in effect for 9 consecutive months.)*

☐ **Value Care - Deductible Options:** ☐ **$600** ☐ **$1200** ☐ **$2000**
Individual Only *(No maternity benefits)*

☐ **Other** _____

☐ **Premier - Deductible Options:** ☐ **$500** ☐ **$1000** ☐ **$2500**
☐ **Individual** *(No maternity benefits)* ☐ **Family** *(Maternity benefits after a member's coverage has been in effect for 9 consecutive months.)*

☐ **High Deductible (HSA-Qualified)**
(Individual/Self only - No maternity benefits)
(2 or 3-Person and Family - Maternity benefits after a member's coverage has been in effect for 9 consecutive months)
☐ Self Only - $1500 Deductible ☐ 3-Person - $5000 Deductible
☐ Self Only - $2500 Deductible ☐ Family - $3000 Deductible
☐ 2-Person - $5000 Deductible ☐ Family - $5000 Deductible

Section 5 Spouse/Dependent Information

Please complete only if your spouse and/or dependent children are applying for coverage.

SPOUSE First Name	MI	Last Name	Gender ☐ M ☐ F	Date of Birth – –	Age	Social Security No. - -
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:	

DEPENDENT 1 First Name	MI	Last Name	Gender ☐ M ☐ F	Date of Birth – –	Age	Social Security No. - -
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:	

DEPENDENT 2 First Name	MI	Last Name	Gender ☐ M ☐ F	Date of Birth – –	Age	Social Security No. - -
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:	

DEPENDENT 3 First Name	MI	Last Name	Gender ☐ M ☐ F	Date of Birth – –	Age	Social Security No. - -
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:	

DEPENDENT 4 First Name	MI	Last Name	Gender ☐ M ☐ F	Date of Birth – –	Age	Social Security No. - -
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:	

Section 5 - Continued

Please answer the following questions if you are applying for any dependents other than your spouse:

☐ 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? If "No," please explain _____
☐ Yes ☐ No	2. Are there court documents establishing the responsible party for providing health coverage for any children for whom you are applying? If "Yes," please submit a complete copy of the final court documents including but not limited to the Final Decree of Divorce, Permanent Parenting Plan or Final Order of Adoption.

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.

Section 6 General Information

Please Read Carefully as this Contains Important Information

You may change from individual coverage to family coverage and add eligible dependents by satisfying certain conditions as determined by Farm Bureau Health Plans ("FBHP"). You must apply for such changes. If your application is approved, the change will become part of your contract. An existing family coverage cannot be modified unless the family unit is broken. The family unit is broken only when all dependents lose eligibility under the existing family coverage or upon the occurrence of certain qualifying events as determined by FBHP. You must apply to modify your family coverage. If your application to modify your family coverage is approved, the change will become a part of your contract.

Individual Coverage has no maternity benefits. Family coverage includes maternity benefits after a member's coverage has been in effect for nine consecutive months.

Quoted premiums are only an estimate. This application will be medically underwritten and FBHP may need to adjust your premium based on the information submitted on the application and any medical information submitted during the underwriting process. In addition to being medically underwritten, FBHP coverages are age-rated. Rate adjustments may occur as the oldest person on the contract ages. Overall general rate adjustments may also be necessary. You will be notified by letter thirty (30) days in advance of any rate adjustment.

THERE IS AT LEAST A 12-MONTH PRE-EXISTING CONDITION WAITING PERIOD FOR ANY CONDITIONS THAT WERE IN EXISTENCE PRIOR TO THE COVERAGE'S EFFECTIVE DATE FOR ANYONE ON THE CONTRACT AGE 19 AND ABOVE. 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 (unless you are a dependent eligible to transfer from an existing FBHP 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 or the Administrator to verify they are not related to a pre-existing condition.

Section 7 Health Questionnaire

Please Read Carefully as this Contains Important Instructions for Completing the Health Questionnaire

All health questions must be answered "Yes" or "No". If any of the answers are "Yes", please provide complete and accurate details in the space provided. We are relying on the information you provide on this application to determine eligibility for coverage for you, your spouse and any children for whom you are applying. Inaccurate or incomplete information provided on this application may constitute misrepresentation. Material misrepresentation could result in amended coverage or termination of coverage. Your full signature is required next to any changes you make to your responses to these questions.

Additional medical information may be needed to complete underwriting. The applicant is responsible for requesting and obtaining medical information from providers and ensuring the medical information is received by FBHP. Any charges rendered by providers associated with obtaining medical information are to be paid by the applicant.

The applicant is encouraged to keep a personal copy of all medical records submitted to FBHP. Once medical records are submitted to FBHP, the applicant must contact the FBHP Privacy Office to obtain a copy of medical records. The applicant will be a charged a fee for the return of medical records.

All persons age 40 and older and children age 25 months and under will automatically receive a request for medical information (details below). This information may be submitted with the application to help expedite the application process.

The following medical records will be required for ages:

(a) 40 and older: COPY OF MEDICAL RECORDS WITH A CURRENT MEDICAL EXAM TO INCLUDE HEIGHT, WEIGHT AND BLOOD PRESSURE READINGS (COMPLETED WITHIN THE LAST 6 MONTHS); A LIST OF CURRENT HEALTH CONDITIONS, CURRENT MEDICATIONS, AND FASTING CHOLESTEROL (LIPID) PANEL TEST RESULTS AND FASTING GLUCOSE (SUGAR) TEST RESULTS (DONE WITHIN THE LAST 12 MONTHS)

(b) 25 months and under: COPY OF MEDICAL RECORDS REGARDING ALL PEDIATRIC VISITS FROM BIRTH TO PRESENT TO INCLUDE THE NEWBORN METABOLIC SCREENING RESULTS, IMMUNIZATION HISTORY OR STATEMENT OF INTENT TO IMMUNIZE

If medical information is not received by FBHP within thirty (30) days from the date of the request, your application for coverage will expire. To reapply for coverage, a new application will be required.

When answering the questions in this application, consider the health of yourself, your spouse and all children for whom you are applying. Claims experience from any previous FBHP plan or UMR policy may be considered during the underwriting process.

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 7 - A — Heart / Circulatory

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1.	Aneurysm	☐ Yes ☐ No	11.	Arrhythmia / Tachycardia / Heart Murmur / Palpitations	☐ Yes ☐ No
2.	Arteriosclerosis / Hardening of the arteries	☐ Yes ☐ No	12.	Heart Attack	☐ Yes ☐ No
3.	Blood Clot / Deep Vein Thrombosis (DVT)	☐ Yes ☐ No	13.	Heart Valve Disease / Replacement	☐ Yes ☐ No
4.	Varicose Veins, Chronic Venous Insufficiency	☐ Yes ☐ No	14.	Congenital Heart Defect	☐ Yes ☐ No
5.	Cardiomyopathy / Enlarged Heart	☐ Yes ☐ No	15.	High Blood Pressure / Hypertension	☐ Yes ☐ No
6.	Chest Pain / Angina	☐ Yes ☐ No	16.	Heart surgery of any type	☐ Yes ☐ No
7.	Congestive Heart Failure	☐ Yes ☐ No	17.	Shunt / Stent placement	☐ Yes ☐ No
8.	Kawasaki Disease	☐ Yes ☐ No	18.	Stroke / TIA	☐ Yes ☐ No
9.	Peripheral Vascular Disease	☐ Yes ☐ No	19.	High Cholesterol / Triglycerides / Lipids	☐ Yes ☐ No
10.	Raynaud's Disease	☐ Yes ☐ No	20.	Other Heart or Circulatory problems	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-A, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Section 7 - B — Hematology

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1.	Anemia of any type	☐ Yes ☐ No	9.	Lymphadenitis / Lymph Node Enlargement	☐ Yes ☐ No
2.	Hemochromatosis	☐ Yes ☐ No	10.	High or Low Platelet Count	☐ Yes ☐ No
3.	Blood Transfusion	☐ Yes ☐ No	11.	High or Low White Blood Cell Count	☐ Yes ☐ No
4.	Hemophilia / other Bleeding Disorder	☐ Yes ☐ No	12.	Leukemia	☐ Yes ☐ No
5.	Blood Clotting Disorder	☐ Yes ☐ No	13.	High or Low Red Blood Cell Count	☐ Yes ☐ No
6.	Acquired Immunodeficiency Syndrome (AIDS)	☐ Yes ☐ No	14.	Enlarged Spleen	☐ Yes ☐ No
7.	Human Immunodeficiency Virus (HIV)	☐ Yes ☐ No	15.	Splenectomy / Surgical Removal of Spleen	☐ Yes ☐ No
8.	Mononucleosis / Epstein-Barr Virus	☐ Yes ☐ No	16.	Other Blood Disease or Disorder	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-B, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 7 - C — Endocrine / Metabolic

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1. Adrenal Gland Disorder	☐ Yes ☐ No	8. Hyperglycemia / Hypoglycemia	☐ Yes ☐ No
2. Addison's Disease	☐ Yes ☐ No	9. Hyperparathyroidism / Hypoparathyroidism	☐ Yes ☐ No
3. Cushing's Syndrome	☐ Yes ☐ No	10. Hyperthyroidism / Hypothyroidism	☐ Yes ☐ No
4. Diabetes / Pre-Diabetes	☐ Yes ☐ No	11. Goiter / Thyroid Nodule / Thyroid Cyst	☐ Yes ☐ No
5. Gestational Diabetes	☐ Yes ☐ No	12. Grave's Disease	☐ Yes ☐ No
6. Impaired Glucose Tolerance	☐ Yes ☐ No	13. Pituitary Tumor / Pituitary Gland Disorder	☐ Yes ☐ No
7. Insulin Resistance	☐ Yes ☐ No	14. Metabolic Syndrome	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-C, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Section 7 - D — Digestive / Gastrointestinal

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1. Stomach or Gastric Ulcers	☐ Yes ☐ No	10. Esophageal Reflux / GERD	☐ Yes ☐ No
2. Hiatal Hernia / Abdominal Hernia	☐ Yes ☐ No	11. Gallbladder Disease / Cholecystitis	☐ Yes ☐ No
3. Colon Polyps	☐ Yes ☐ No	12. Pancreatitis	☐ Yes ☐ No
4. Diverticulitis / Diverticulosis	☐ Yes ☐ No	13. Hepatitis	☐ Yes ☐ No
5. Crohn's Disease	☐ Yes ☐ No	14. Liver Cyst(s) or Abscess	☐ Yes ☐ No
6. Irritable Bowel Syndrome / IBS	☐ Yes ☐ No	15. Gastric Bypass / Lap Band / Weight Loss Surgery	☐ Yes ☐ No
7. Ulcerative Colitis	☐ Yes ☐ No	16. Enlarged Liver / Elevated Liver Enzymes (ALT/LFT)	☐ Yes ☐ No
8. Hemorrhoids	☐ Yes ☐ No	17. Cirrhosis of Liver	☐ Yes ☐ No
9. Esophageal Stricture	☐ Yes ☐ No	18. Other Conditions of the Digestive System.	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-D, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 7 - E — Kidney / Urinary

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1.	Cystitis / Bladder Infections / UTI	☐ Yes ☐ No	10.	Birth Defects of Kidney / Ureter / Bladder	☐ Yes ☐ No
2.	Blood / Protein in Urine	☐ Yes ☐ No	11.	Kidney Transplant or Dialysis	☐ Yes ☐ No
3.	Interstitial Cystitis	☐ Yes ☐ No	12.	Chronic Kidney Disease	☐ Yes ☐ No
4.	Urinary / Stress Incontinence	☐ Yes ☐ No	13.	Nephrectomy / Surgical Removal of Kidney	☐ Yes ☐ No
5.	Urethral Stricture	☐ Yes ☐ No	14.	Renal Failure	☐ Yes ☐ No
6.	Kidney Stones	☐ Yes ☐ No	15.	Elevated Prostate-Specific Antigen (PSA)	☐ Yes ☐ No
7.	Kidney Reflux	☐ Yes ☐ No	16.	Enlarged Prostate / Benign Prostatic Hypertrophy (BPH)	☐ Yes ☐ No
8.	Kidney Infection	☐ Yes ☐ No	17.	Chronic or Recurring Prostatitis	☐ Yes ☐ No
9.	Polycystic Kidney	☐ Yes ☐ No	18.	Other Kidney / Urinary Disorders	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-E, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Section 7 - F — Reproductive

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

FEMALE

1.	Irregular Menstrual Bleeding	☐ Yes ☐ No	8.	Breast Implants: ☐Silicone ☐Saline ☐Other	☐ Yes ☐ No
2.	Abnormal PAP Smear	☐ Yes ☐ No	9.	Pregnancy Complications	☐ Yes ☐ No
3.	Sexually Transmitted Disease (STD)	☐ Yes ☐ No	10.	Endometriosis	☐ Yes ☐ No
4.	Herpes Simplex Virus (HSV)	☐ Yes ☐ No	11.	Uterine Fibroids	☐ Yes ☐ No
5.	Human Papilloma Virus (HPV) / Genital Warts	☐ Yes ☐ No	12.	Polycystic Ovaries / Ovarian Cyst	☐ Yes ☐ No
6.	Abnormal Mammogram / Ultra Sound / Breast Exam	☐ Yes ☐ No	13.	Hysterectomy: ☐ Partial ☐ Complete	☐ Yes ☐ No
7.	Breast Biopsy	☐ Yes ☐ No	14.	Hormone Replacement Therapy	☐ Yes ☐ No

MALE

15.	Hydrocele / Varicocele / Spermatocele	☐ Yes ☐ No	18.	Sexually Transmitted Disease (STD)	☐ Yes ☐ No
16.	Undescended Testicle	☐ Yes ☐ No	19.	Herpes Simplex Virus (HSV)	☐ Yes ☐ No
17.	Hormone Replacement Therapy	☐ Yes ☐ No	20.	Human Papilloma Virus (HPV) / Genital Warts	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-F, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 7 - G	Musculoskeletal		
During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?			
1. Amputations / Birth Defects / Prosthesis	☐ Yes ☐ No	13. Bone Spurs	☐ Yes ☐ No
2. Osteoarthritis / Degenerative Joint Disease	☐ Yes ☐ No	14. Bunion / Hammertoe	☐ Yes ☐ No
3. Rheumatoid Arthritis	☐ Yes ☐ No	15. Plantar Fasciitis	☐ Yes ☐ No
4. Elevated or Positive Antinuclear Antibody (ANA)	☐ Yes ☐ No	16. Osteoporosis / Osteopenia	☐ Yes ☐ No
5. Gout, Gouty Arthritis	☐ Yes ☐ No	17. Temporal Mandibular Joint Dysfunction (TMJ)	☐ Yes ☐ No
6. Psoriatic Arthritis	☐ Yes ☐ No	18. Joint Dislocation / Joint Replacement	☐ Yes ☐ No
7. Reiter's Syndrome	☐ Yes ☐ No	19. Spina Bifida / Spina Bifida Occulta	☐ Yes ☐ No
8. Bursitis / Tendinitis	☐ Yes ☐ No	20. Back or Neck Injury / Pain	☐ Yes ☐ No
9. Carpel Tunnel syndrome	☐ Yes ☐ No	21. Herniated Disc / Ruptured Disc	☐ Yes ☐ No
10. Fibromyalgia	☐ Yes ☐ No	22. Sciatica / Sacroiliitis / Radiculitis/ Spinal Stenosis	☐ Yes ☐ No
11. Systemic Lupus Erythematous (SLE)	☐ Yes ☐ No	23. Scoliosis / Curvature of the Spine	☐ Yes ☐ No
12. Connective Tissue Diseases of any type	☐ Yes ☐ No	24. Degenerative Disc Disease	☐ Yes ☐ No

25. Any chiropractic treatment? If "Yes," please specify: ☐ For symptoms of pain or discomfort? ☐ For wellness or maintenance only?	☐ Yes ☐ No
26. Hip pain, injury, or other conditions of the hip? If "Yes," specify which: ☐ Right ☐ Left ☐ Both (*List details below*)	☐ Yes ☐ No
27. Knee pain, injury, or other conditions of the knee? If "Yes," specify which: ☐ Right ☐ Left ☐ Both (*List details below*)	☐ Yes ☐ No
28. Ankle / Foot pain, injury or other conditions of the Ankle / Foot? If "Yes," specify which: ☐ Right ☐ Left ☐ Both (*List details below*)	☐ Yes ☐ No
29. Shoulder pain, injury, or other conditions of the shoulder? If "Yes," specify which: ☐ Right ☐ Left ☐ Both (*List details below*)	☐ Yes ☐ No
30. Elbow / Wrist pain, injury or other conditions of the Elbow / Wrist? If "Yes," specify which: ☐ Right ☐ Left ☐ Both (*List details below*)	☐ Yes ☐ No
31. Joint internal / external fixations, screws, plates, or rods? If "Yes," specify location and type in space provided below.	☐ Yes ☐ No
32. Physical Therapy or Steroid Injections for any type of injury, inflammation or pain?	☐ Yes ☐ No

If you answered "Yes" to any of the above questions listed in Section 7-G, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? ☐ Yes - Ongoing ☐ No - Resolved	**Was Surgery Performed?** ☐ Yes - (MM/YY) __________ ☐ No	**What medications do you take for this condition or illness?**		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? ☐ Yes - Ongoing ☐ No - Resolved	**Was Surgery Performed?** ☐ Yes - (MM/YY) __________ ☐ No	**What medications do you take for this condition or illness?**		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? ☐ Yes - Ongoing ☐ No - Resolved	**Was Surgery Performed?** ☐ Yes - (MM/YY) __________ ☐ No	**What medications do you take for this condition or illness?**		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? ☐ Yes - Ongoing ☐ No - Resolved	**Was Surgery Performed?** ☐ Yes - (MM/YY) __________ ☐ No	**What medications do you take for this condition or illness?**		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 7 - H — Brain / Neurological / Behavioral

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1.	Amnesia / Coma	☐ Yes ☐ No	15.	Tourette Syndrome / Tics / Tremor of any type	☐ Yes ☐ No
2.	Alzheimer's / Dementia	☐ Yes ☐ No	16.	Restless Leg Syndrome	☐ Yes ☐ No
3.	Concussion / Head Injury	☐ Yes ☐ No	17.	Reflex Sympathetic Dystrophy (RSD)	☐ Yes ☐ No
4.	Abscess, Cyst, or Tumor of the Brain	☐ Yes ☐ No	18.	Insomnia / Problems with Sleep / Sleep Disorder	☐ Yes ☐ No
5.	Encephalitis / Hydrocephalus	☐ Yes ☐ No	19.	Narcolepsy / Cataplexy	☐ Yes ☐ No
6.	Meningitis	☐ Yes ☐ No	20.	Down's Syndrome	☐ Yes ☐ No
7.	Headaches / Migraines	☐ Yes ☐ No	21.	Autism / Asperger's Syndrome	☐ Yes ☐ No
8.	Black-outs / Syncope / Fainting	☐ Yes ☐ No	22.	Pervasive Development Disorder of any type	☐ Yes ☐ No
9.	Epilepsy / Seizure of any type / Convulsions	☐ Yes ☐ No	23.	Anxiety / Depression / OCD / Panic Attacks	☐ Yes ☐ No
10.	Multiple Sclerosis (MS) / Muscular Dystrophy	☐ Yes ☐ No	24.	Bi-Polar / Chemical Imbalance / Mood Disorder	☐ Yes ☐ No
11.	Paralysis	☐ Yes ☐ No	25.	ADD / ADHD / Adjustment Disorder of any type	☐ Yes ☐ No
12.	Any form of Neuralgia, Neuritis, or Neuropathy	☐ Yes ☐ No	26.	Anorexia / Bulimia / Eating Disorder of any type	☐ Yes ☐ No
13.	Cerebral Palsy	☐ Yes ☐ No	27.	Self-Inflicted injury / Suicidal Thoughts / Suicide Attempt	☐ Yes ☐ No
14.	Lou Gehrig's / Parkinson's Disease	☐ Yes ☐ No	28.	Counseling / Therapy of any type	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-H, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Section 7 - I — Lung / Respiratory

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1.	Allergies / Allergy Immunotherapy / Allergy Shots	☐ Yes ☐ No	8.	Cystic Fibrosis	☐ Yes ☐ No
2.	Asthma / Reactive Airway Disease (RAD)	☐ Yes ☐ No	9.	Tuberculosis	☐ Yes ☐ No
3.	Abnormal Chest X-ray / MRI / CT of Lung	☐ Yes ☐ No	10.	Sarcoidosis / Granuloma of the Lung	☐ Yes ☐ No
4.	Abscess / Cyst / Lesion / Tumor of the Lung	☐ Yes ☐ No	11.	Pleurisy / Pneumonia	☐ Yes ☐ No
5.	Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes ☐ No	12.	Respiratory Syncytial Virus (RSV)	☐ Yes ☐ No
6.	Emphysema	☐ Yes ☐ No	13.	Chronic / Recurrent Tonsillitis / Enlarged Tonsils	☐ Yes ☐ No
7.	Chronic coughing / Coughing up blood	☐ Yes ☐ No	14.	Sleep Apnea	☐ Yes ☐ No

15. Been advised to have a sleep study? ☐ Yes ☐ No If "Yes," when was sleep study performed? (MM/YY) _____

16. Do you currently use a C-PAP machine? ☐ Yes ☐ No If "Yes," how long have you used it consistently? _____ Year(s) _____ Month(s)

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-I, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 7 - J — Ear / Eye / Nose / Throat

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1. Cholesteatoma / Cyst of Ear	☐ Yes ☐ No	10. Retinal Detachment / Hemorrhage / Tear	☐ Yes ☐ No
2. Deafness	☐ Yes ☐ No	11. Double Vision	☐ Yes ☐ No
3. Vertigo / Meniere's Disease	☐ Yes ☐ No	12. Ptosis / Drooping Eyelid	☐ Yes ☐ No
4. Chronic or Recurring Ear Infections	☐ Yes ☐ No	13. Glaucoma	☐ Yes ☐ No
5. Ear Tubes ☐ Currently in Place ☐ No Longer in Place	☐ Yes ☐ No	14. Cleft Palate / Cleft Lip	☐ Yes ☐ No
6. Other Condition or Problem of the Ear(s)	☐ Yes ☐ No	15. Chronis / Recurring Sinusitis	☐ Yes ☐ No
7. Blindness / Partial Blindness	☐ Yes ☐ No	16. Deviated Septum	☐ Yes ☐ No
8. Cataracts	☐ Yes ☐ No	17. Vocal Chord Polyps / Paralysis	☐ Yes ☐ No
9. Corneal Implants / Ulcer	☐ Yes ☐ No	18. Other Condition or Problem of the Throat	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-J, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Section 7 - K — Skin

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1. Eczema / Rosacea	☐ Yes ☐ No	6. Darier's Disease	☐ Yes ☐ No
2. Psoriasis	☐ Yes ☐ No	7. Abnormal Moles / Abnormal Skin Lesions	☐ Yes ☐ No
3. Seborrheic Dermatitis / Keratosis	☐ Yes ☐ No	8. Cyst / Tumor of Skin	☐ Yes ☐ No
4. Shingles / Herpes Zoster	☐ Yes ☐ No	9. Skin Cancer	☐ Yes ☐ No
5. Acne	☐ Yes ☐ No	10. Biopsy of Skin / Biopsy of Skin Lesion	☐ Yes ☐ No

If you answered "Yes" to <u>any</u> of the above questions listed in Section 7-K, please explain below and provide full details.

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:

Is the Condition still present?	Was Surgery Performed?	What medications do you take for this condition or illness?
☐ Yes - Ongoing ☐ No - Resolved	☐ Yes - (MM/YY) _____ ☐ No	

Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 7 - L Miscellaneous Questions

When answering the following questions, consider the health of yourself, your spouse and all dependent children for whom you are applying:

1. Has any applicant been rejected for coverage, issued a limited policy or issued a policy with increased premium for life, health, or disability coverage? If "Yes," ☐ Yes ☐ No
   Applicant name(s): _____ Reason: _____
2. Is any applicant currently on disability of any type? If "Yes," ☐ Yes ☐ No
   Applicant name(s): _____ Reason: _____
3. Is any applicant currently covered under worker's compensation? If "Yes," ☐ Yes ☐ No
   Applicant name(s): _____ Reason: _____
4. Is any male applicant expecting a child with anyone, whether or not listed on this application? *If "Yes," the completion of a Newborn Waiver is required.* ☐ Yes ☐ No
5. Is any female applicant currently pregnant or has any female applicant tested positive using a home pregnancy test? *If "Yes," the completion of a Newborn Waiver is required.* ☐ Yes ☐ No
   Applicant name(s): _____ How many months pregnant? _____ What is the current pregnancy weight? _____
6. Have you or anyone for whom you are applying, experienced weight gain or loss of more than 20 pounds in the past 12 months? If "Yes," ☐ Yes ☐ No
   Applicant name(s): _____ Reason for weight gain or loss: _____
7. Within the past 10 years, has any applicant been treated, diagnosed with, or discussed with a physician the need to reduce alcohol, chemical, prescription or substance use or abuse? If "Yes," ☐ Yes ☐ No
   Applicant Name(s) _____
8. Within the past 10 years, has any applicant ever used illegal controlled drugs (prescription medications) or other substances such as marijuana, cocaine, methamphetamine, or intravenous (IV) drugs? If "Yes," ☐ Yes ☐ No
   Applicant name(s): _____ Type of drug/substance: _____ Date discontinued: _____
9. Has any applicant attended counseling, Alcoholics Anonymous (AA) or support groups for alcohol or drug use within the last 10 years? If "Yes," ☐ Yes ☐ No
   Applicant name(s) _____ Date started: _____ Date ended: _____
10. Within the past 10 years, has any applicant been treated for Chronic Pain with use of pain medications including but not limited to: Oxycontin, Lortab, Morphine, or other pain medications? If "Yes," ☐ Yes ☐ No
    Applicant name(s): _____ Name of Medication(s) : _____
11. Is any applicant currently being treated or has any applicant been treated through a Pain Management Center? If "Yes," ☐ Yes ☐ No
    Applicant name(s) _____ Date started: _____ Date ended: _____
12. Has any applicant been advised to have surgery / biopsy that has not been completed? If "Yes," ☐ Yes ☐ No
    Applicant name(s): _____ Type of surgery / biopsy: _____
    Explain why the surgery / biopsy has not been completed _____
13. Has any applicant been advised to have testing done that has not been completed? (i.e. blood work, x-ray, CT, MRI, Ultrasound, etc.) If "Yes," ☐ Yes ☐ No
    Applicant name(s): _____ Type of test(s): _____
    Explain why the test has not been completed: _____
14. In the last 3 years, has any applicant been referred to a medical specialist of any kind? (i.e. Cardiologist, Endocrinologist, Oncologist, Neurologist, Pulmonologist, Urologist, etc.) If "Yes," ☐ Yes ☐ No
    Applicant name(s): _____ Type of Specialist: _____
    Doctor's Name: _____ Reason for referral: _____
15. In the last 12 months, has any applicant been seen in the Emergency room? If "Yes," ☐ Yes ☐ No
    Applicant name(s): _____ Reason: _____

List all medications that are currently being taken or that have been taken in the last three (3) years for you, your spouse, and any children for whom you are applying. If necessary, please add a separate page with additional information.

Applicant's Name	Name of Medication(s)	What illness or condition is this medication treating?	Is medication currently being taken?	Date Started	Date Stopped

TRH HEALTH INS. CO.

Primary Applicant First Name	MI	Last

Section 8 Acknowledgements and Agreements

Please Read Carefully and Initial Below

I understand and acknowledge:

- Any coverage which may be issued will contain a pre-existing condition waiting period of at least 12 months. ***(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. In applying for this coverage, I understand and acknowledge that UMR (the Administrator) makes available to individuals other health coverage plans which do not require medical underwriting and do not contain 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 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. ***(Please initial here:_____)***

IMPORTANT: The approval of this application is subject to medical underwriting guidelines. If you have current coverage, do not cancel your current coverage until you have been issued coverage by FBHP and upon review, agree to accept the rate, terms and conditions of the contract.

Should this change require re-issuance, your Plan ID card(s) and contract should arrive within a few days of the billing. Please review both the identification card(s) and the contract carefully, as they contain important information. You will have 30 days from the date you receive your contract to decide if you want to continue the coverage.

Please Read Carefully and Sign Below

FBHP and the Administrator are 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:

- 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
- 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, the Administrator 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 and the Administrator 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.

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 or the Administrator for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of 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**

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

TRHH is a wholly owned subsidiary of Farm Bureau Health Plans ("FBHP"). FBHP is a taxable, not-for-profit, membership organization which promotes health care for Tennesseans by providing a program of benefits to its members and members of the Tennessee Farm Bureau Federation. Members can learn more about the programs and services offered through their local Farm Bureau office.