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FBHP MEDICARE SUPPLEMENT PLAN SELECTION FORM

BL-FM-FL19-160

For Use by FBHP current subscribers only

This form is for a current Farm Bureau Health Plans (FBHP) subscriber who is requesting to transition into an FBHP Medicare Supplement Plan on the date indicated below. **PLEASE NOTE**—it is important to return this form timely so there will be no gap in coverage between the current plan and your FBHP Medicare Supplement. Accumulation of deductibles, out-of-pocket amounts and other current plan accumulators will restart with the FBHP Medicare Supplement plan.

FOR OFFICE USE ONLY	Effective date of FBHP Medicare Supplement Plan:
Subscriber Name	Current Health Plan ID No.
Date of Birth	County TFB Membership No.
Phone	Email (For communication with FBHP only)

To enroll for an FBHP Medicare Supplement, you must be:
1) Age 65 or older and enrolled in Medicare Part A and Part B or
2) Under age 65 and enrolled in Medicare Part A and Part B due to a disability or End Stage Renal Disease.

Fill out each section below exactly as it appears on your Medicare Card or attach a copy of your Medicare card or letter from Social Security or the Railroad Retirement Board.

Name_____

Medicare Number:_____

Hospital (Part A) Start Date:_____

Medical (Part B) Start Date:_____

1. I select FBHP Medicare Supplement Plan:
   Plan A_____ Plan B_____ Plan D_____ Plan G_____ Plan M_____ Plan N_____ Other_____
2. I understand I do not need more than one Medicare Supplement insurance plan.
3. I have received an Outline of Coverage for FBHP Medicare Supplements.
4. I hereby authorize FBHP to continue to debit entries from my account previously identified on my FBHP Health plan for this newly selected FBHP Medicare Supplement insurance plan.
5. I understand Federal law prohibits an employer from making payment for a Medicare Supplement plan for an active employee.

It is a crime to knowingly provide false, incomplete information for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of coverage.

Subscriber Signature: X_____ Date:_____

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