

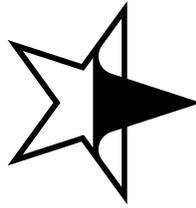


# Texas Farm Bureau Health Plans

## Alternative Plan Selection | Transfer | Change Form

Texas Farm Bureau Health Plans  
 PO Box 1424  
 Columbia, TN 38402-1424  
 Phone: 877-500-0140  
 Fax: 931-560-4278  
[billingforms@fbhp.com](mailto:billingforms@fbhp.com)

General Information					
Upon completion, please submit to address, fax or email above.				<b>Original ID Number:</b>	
Section 1 Subscriber Information					
First Name		MI	Last Name		
Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number	
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (DATE): _____				Date of Marriage/Divorce	
Mailing Address <small>If this is a new address, check this box:</small> <input type="checkbox"/>					
City		State	Zip	TX Farm Bureau Membership Number	
Phone Number		Email Address (by providing your email address, you agree to receive electronic communications from TFBHP)			
Section 2 Reason for Change					
<input type="checkbox"/> <b>Alternative Plan Option</b> <input type="checkbox"/> <b>Transfer Option</b> - List the plan/deductible below. - List any previously approved dependents you wish to have on your plan in Section 3					
<b>Plan Name:</b>		<b>Deductible:</b>		<input type="checkbox"/> <b>Individual Coverage</b> <input type="checkbox"/> <b>Family Coverage</b>	
By signing the form below, I understand and acknowledge:					
<ul style="list-style-type: none"> <li>- This acceptance form shall supplement my previously submitted Texas Farm Bureau Health Plans Traditional Membership Application, and all terms of such are incorporated within.</li> <li>- TFBHP has offered and I am selecting the plan listed above as health care coverage for the member listed in Section 1 and any dependents in Section 3.</li> <li>- The offer is time sensitive and must be returned to TFBHP within 30 days of the date of the offer letter or the offer of coverage will be revoked.</li> <li>- I have fully read, understand, and agree to all terms and conditions and hereby accept the designated plan listed above for healthcare coverage.</li> </ul>					
<input type="checkbox"/> <b>Name Change</b>	Change name to		Former Name		
<input type="checkbox"/> <b>Request Plan Effective Date Change</b>					
<input type="checkbox"/> <b>Change my Coverage</b>	(NOTE: Once you change coverage, you will not be able to go back to the previous plan unless you re-apply) Plan Name: _____ Deductible: _____				
<input type="checkbox"/> <b>Dependent Change</b>	Maternity Benefits   Individual Coverage: No maternity benefits provided, unless Classic Plan. Family Coverage: Maternity benefits available after coverage has been in effect for six consecutive months. Additional documentation may be required if adding or deleting spouse/dependent(s). List date of marriage or divorce if applicable.				
	<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)		
Section 3 Dependents (For Accepting Underwriting Option or Dependent Change Only)					
<b>DEPENDENT 1</b> First Name		MI	Last Name		
Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth/ Death	Age
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (DATE): _____				Date of Marriage/Divorce	Relationship to Subscriber
<b>DEPENDENT 2</b> First Name		MI	Last Name		
Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth/ Death	Age
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (DATE): _____				Date of Marriage/Divorce	Relationship to Subscriber
<b>DEPENDENT 3</b> First Name		MI	Last Name		
Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth/ Death	Age
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (DATE): _____				Date of Marriage/Divorce	Relationship to Subscriber
Section 4 Acknowledgement					
<b>It is a crime to knowingly provide false, incomplete information for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. A scanned, image or photocopied version of this completely executed form will have the same force and effect as the original document.</b>					
Subscriber Signature _____				Today's Date _____	



# TEXAS FARM BUREAU<sup>®</sup> HEALTH PLANS

Texas Farm Bureau Health Plans  
PO Box 1424  
Columbia, TN 38402-1424  
Phone: 833-282-5928  
Billing Fax: 931-560-4278  
billingmfp@fbhealthplans.com

## Bank Draft Authorization Form

### General Information

- All requested information below is required to authorize your automatic bank draft.
- Upon completion, please submit to address, fax or email above.
- For bank changes, the form must be received by the 20<sup>th</sup> of the month to be effective the first of the following month.
- Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.
- **Cancellation**- the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to Texas Farm Bureau Health Plans. Coverage will remain in effect until the paid-to-date. See your contract for specific information regarding cancellations and cancellations due to death of Subscriber.

### Applicant/Subscriber Information

First Name	MI	Last Name
Requested Date of Change	Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number

### Banking Information

Authorization Type <input type="checkbox"/> New Applicant <input type="checkbox"/> Existing Subscriber	Requested Date of Change (for existing Subscribers)
Please complete or attach voided check. Account Type: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	
Name of Financial Institution	
Address of Financial Institution	
Routing Number	Account Number

### Authorization

I hereby authorize Texas Farm Bureau Health Plans to initiate debit entries from the account indicated above for the monthly payment of health and/or dental coverage. The depository named above 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 understand I have the right to revoke this authorization by notifying Texas Farm Bureau Health Plans in writing at least ten (10) days prior to the time payment is due. I further agree that should a debit be dishonored, whether with or without a cause and whether intentionally or inadvertently, Texas Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Applicant/Subscriber Printed Name (Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)	Payor Printed Name
Applicant/Subscriber Signature	Payor Signature
Today's Date	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.*