Texas Farm Bureau Health Plans
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TFBHP MEDICARE SUPPLEMENT PLAN SELECTION FORM

For Use by TFBHP current subscribers only

This form is for a current Texas Dakota Farm Bureau Health Plans (TFBHP) subscriber who is requesting to transition into an TFBHP 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 TFBHP Medicare Supplement. Accumulation of deductibles, out-of-pocket amounts and other current plan accumulators will restart with the TFBHP Medicare Supplement plan.

FOR OFFICE USE ONLY	Effective date of TFBHP Medicare Supplement Plan:
Subscriber Name	Current Health Plan ID No.
Date of Birth	Gender ☐ Male ☐ Female — Texas FB Membership No.
Phone	Email (For communication with TFBHP only)

To enroll for an TFBHP 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) StartDate:_____

1. I select TFBHP Medicare Supplement Plan:
   Plan A_____Plan D_____Plan G_____Plan N_____
   I understand I do not need more than one Medicare Supplement insurance plan.
2. I have received an Outline of Coverage for TFBHP Medicare Supplements.
3. I hereby authorize TFBHP to continue to debit entries from my account previously identified on my TFBHP Health plan for this newly selected TFBHP Medicare Supplement insurance plan.
4. 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.