Medicare Supplement Plan Change Form
Group Plans Effective Post 2021

Farm Bureau Health Plans
PO Box 313
Columbia, TN 38402-0313
Phone: 877-874-8323
Billing Fax: 931-560-4278
BillingForms@fbhealthplans.com

General Information

First Name	MI	Last Name	
Subscriber ID #	Social Security #	Date of Birth	Gender ☐ Female ☐ Male
Mailing Address			
City / State / Zip Code		Phone No.	
Email Address (by providing your email address, you agree to receive electronic communications from FBHP)			

Change in Coverage (Medicare Replacement Form Required)

Drop	I understand and acknowledge: **I am requesting a plan with less benefits than the plan I currently have.**
Upgrade	I understand and acknowledge: **I am requesting to change to a plan with more benefits than the plan I currently have. If I elect to upgrade my coverage, I must answer the health questions below and be approved by FBHP.**

I wish to change my current Medicare Supplement plan to (select one):

Plan A	Plan D	Plan G	Plan N

Health Questions – If *upgrading* coverage, the following questions are required to be completed.

Farm Bureau Health Plans Underwriting Department may review all current health conditions, medications, and/or treatment to determine if you are eligible for a plan with more benefits based on our current underwriting standards. Claims experience from any previous FBHP coverage may be used in this process.

In the last five (5) years, have you been treated for any of the following medical conditions:

Yes	No	#	Condition	If "Yes," when?
Yes	No	1	Heart Attack or Congestive Heart Failure?	If "Yes," when?
Yes	No	2	Cancer (Not Skin Cancer)?	If "Yes," when?
Yes	No	3	Stroke or Trans Ischemic Attack (TIA)?	If "Yes," when?
Yes	No	4	Kidney Failure or Chronic Kidney Disease?	If "Yes," when?
Yes	No	5	Diabetes?	If "Yes," when?
Yes	No	6	Parkinson's Disease?	If "Yes," when?
Yes	No	7	Multiple Sclerosis or Lou Gehrig's Disease (ALS)?	If "Yes," when?
Yes	No	8	Muscular Dystrophy?	If "Yes," when?
Yes	No	9	Emphysema or COPD?	If "Yes," when?
Yes	No	10	Alzheimer's Disease or Dementia?	If "Yes," when?
Yes	No	11	Cirrhosis of the liver?	If "Yes," when?
Yes	No	12	Huntingdon's disease?	If "Yes," when?

Authorization

I declare that all the foregoing statements provided by me in this form in its entirety are true, correct and complete to the best of my knowledge and belief. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Subscriber Signature　　　　　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. Please return a copy of this form to the address, fax or email above.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

TRH HEALTH INSURANCE COMPANY

Home Office: P.O. Box 313, Columbia, TN 38402-0313, 1-877-874-8323

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by TRH Health Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURANCE COMPANY

We have reviewed your current medical or health insurance coverage. To the best of our knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons (check one):

_____ Additional benefits.
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
_____ Disenrollment from a Medicare Advantage plan. Please explain the reason for disenrollment:
____
_____ Other (please specify): ____

(1) Note: If the insurance company of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

TRH HEALTH INSURANCE COMPANY

Applicant Signature ____ Date ___________________