FARM BUREAU HEALTH PLANS
DENTALVISION SILVER APPLICATION

PLEASE PRINT USING BLACK INK

County Office or FBHP Agent Use Only			
Subgroup	County Office	FBHP Agent	Requested Effective Date

Section 1 – Primary Applicant Information

First Name	MI	Last Name	

Date of Birth	Age	Gender	Social Security No.
		☐ Male ☐ Female	

Marital Status	I am a United States Citizen or Legal Resident
☐ Single ☐ Married	☐ Yes ☐ No

Mailing Address (please include your apartment or suite number)

City	County	State	Zip Code

Phone No. ( ) _____ - _____ Alternate No. ( ) _____ - _____

Email Address (by providing your email address, you agree to receive electronic communications from Farm Bureau Health Plans)

How did you hear about FHBP?

☐ Internet ☐ TV ☐ Phone Book ☐ Radio ☐ Mail Ad ☐ Billboard ☐ TN Farm Bureau ☐ Family/Friend

Section 2 – Application Information

☐ Yes ☐ No

Are you an existing TN Farm Bureau member?

If "No", please submit a TN Farm Bureau Membership Application and Agreement. If "Yes", please complete the following information:

TN Farm Bureau membership is in the name of: _____

TN Farm Bureau Membership Number: _____

☐ New Application For Coverage

☐ Reapplication – Current Farm Bureau Health Plans member re-applying for new coverage

Current FBHP ID Number (if making change to your current Farm Bureau Health Plans Coverage):

Section 3 – Coverage Option

☒ DentalVision Silver Individual Coverage

Section 4 – Coverage Information

Please provide your Medicare effective date information below.
This will determine eligibility and if a dental benefit waiting period will apply for this coverage.

Medicare Part A Effective Date:		Medicare Part B Effective Date:	

Internal Use Only

First Name | MI | Last Name

Section 5 – Acknowledgements and Agreements

Please read carefully and initial

I understand and acknowledge:	Initial here:
To apply for this plan, you must be eligible for Medicare and agree to the terms and conditions as designated below. The plan applied for with Farm Bureau Health Plans contains a dental benefit waiting period of one hundred and eighty (180) days unless certain conditions are met. If you do not qualify for a waiver of the dental benefit waiting period, certain dental benefits will not be available until the one hundred and eighty-first (181st) day of your coverage. Your Farm Bureau Health Plans contract and Plan ID card should arrive within a few days of enrollment. Please review both the Plan ID card and the contract carefully as they contain important information about your plan including any applicable waiting periods. 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

Farm Bureau Health Plans is entitled to rely 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 Plan ID 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 Farm Bureau Health Plans program as determined solely by Farm Bureau Health Plans.

If I am not already a member, I hereby make application for membership in the Tennessee Farm Bureau/Farm Bureau Health Plans. I understand this membership entitles me to apply for the services offered by Farm Bureau Health Plans and the Tennessee Farm Bureau.

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to Farm Bureau Health Plans for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of coverage.

Acknowledgement for Individual Coverage

Applicant must sign and date the application, acknowledging their understanding of and agreement to the conditions listed above.

	Applicant 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.

Farm Bureau Health Plans is a taxable, not-for-profit, membership organization which promotes health care for Tennesseans. Members can learn more about the programs and services offered by Farm Bureau Health Plans through their local Tennessee Farm Bureau office.

Internal Use Only

Bank Draft Authorization Form

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

County Office or FBHP Agent Use Only

Subgroup	County	Branch

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 at FBHP by the 20th 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 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	Requested Date of Change (for existing Subscribers)
☐ New Applicant ☐ Existing Subscriber	

Please complete or attach voided check.

Account Type: ☐ Checking Account ☐ Savings Account

Name of Financial Institution

Address of Financial Institution

Routing Number	Account Number

Authorization

I hereby authorize Farm Bureau Health Plans to initiate debit entries from the account indicated below for the monthly payment of health and/or dental coverage. The depository named below 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 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, 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	**Today's Date**	**Payor Signature**	**Today's Date**

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FARM BUREAU HEALTH PLANS
DENTALVISION SILVER
APPLICATION CHECKLIST

☐ **Section 1 – Primary Applicant Information**

- Complete with your current information.

☐ **Section 2 – Application Information**

- Complete the Tennessee Farm Bureau Membership and coverage information. Select the type of application.

☐ **Section 4 – Coverage Information**

- Enter dates for Medicare Part A and/or Part B. You must have Medicare in order to be eligible to apply for this coverage.

☐ **Section 5 – Acknowledgements and Agreements**

- Read, initial and sign the appropriate areas to acknowledge your understanding.
- Please thoroughly review and sign your full name beside any changes or mistakes made on the application (even if white-out is used).
- Check the date that the application is signed. We cannot accept an application more than 30 days old.

☐ **FBHP Bank Draft Authorization Form**

- Complete the FBHP Bank Draft Authorization (including payor information).

☐ **Tennessee Farm Bureau Membership**

- Complete the Farm Bureau Membership Application and Agreement form with EFT Authorization if you are not currently a member.

☐ **Return to Farm Bureau Health Plans**

- Mail (completed FBHP application, Bank Draft Authorization Form, Farm Bureau Membership Application with EFT Authorization, if applicable) to P.O. Box 313, Columbia, TN 38402-0313, or deliver to your local Farm Bureau office. Visit fbhealthplans.com to locate an office near you.

Farm Bureau Health Plans toll-free number is 877-874-8323, 7:00 a.m. – 5:00 p.m., CST

Don't forget!

Your Farm Bureau membership means you have access to an array of services -- including automobile, homeowners and life insurance products, and discounts for security systems, cellular phone service and hotels.

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