FARM BUREAU HEALTH PLANS
TRADITIONAL MEMBERSHIP HEALTH PLAN APPLICATION

PLEASE PRINT USING BLACK INK

County Office or FBHP Representative Use Only

Subgroup	County Office	FBHP Representative	Requested Effective Date

Section1 – Primary Applicant Information

First Name	MI	Last Name

Date of Birth	Age	Gender	Social Security No.	I am a United States Citizen or Legal Resident
		☐ Male ☐ Female		☐ Yes ☐ No

Marital Status	Tobacco Use:		Height	Weight
☐ Single ☐ Married	☐ No	☐ Yes - within the last 24 months ☐ Yes - more than 24 months ago		

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. Your decision to opt-in will not affect your eligibility of coverage or services. You may withdraw your consent at any time by calling 877-874-8323.)

How did you hear about us? ☐ Internet ☐ TV ☐ Phone Book ☐ Radio ☐ Mail Ad ☐ Billboard ☐ Family/Friend ☐ TN Farm Bureau

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 (required for enrollment). 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	☐ Add Dependent to: ☐ Existing Family Coverage ☐ Existing Individual Coverage (Changing to Family Coverage)	☐ Transfer From Other Farm Bureau Health Plans Coverage

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

Section 3 – Coverage Options

The following coverage options contain a 12 month pre-existing condition waiting period

☐ Major Medical	☐ Individual - $7500 Deductible (No maternity benefits)	☐ Family - $7500 Deductible (Maternity benefits available after a member's family coverage has been in effect for 9 consecutive months)	
☐ High Deductible (HSA-Qualified)	☐ Self Only - $2250 Deductible ☐ Self Only - $3750 Deductible (No maternity benefits)	☐ 2-Person - $7500 Deductible ☐ 3-Person - $7500 Deductible (Maternity benefits available after a member's family coverage has been in effect for 9 consecutive months)	☐ Family - $4500 Deductible ☐ Family - $7500 Deductible (Maternity benefits available after a member's family coverage has been in effect for 9 consecutive months)
☐ Other: _____		☐ Individual ☐ Family	

The following coverage options contain a 6 month pre-existing condition waiting period.

☐ Core Choice	☐ Child Coverage - $1500 Deductible ☐ Child Coverage - $3000 Deductible (Available to children age 18 or under) (No maternity benefits)	☐ Individual - $1500 Deductible ☐ Individual - $3000 Deductible (No maternity benefits)	☐ Family - $1500 Deductible ☐ Family - $3000 Deductible (Maternity benefits available after a member's family coverage has been in effect for 9 consecutive months)
☐ Enhanced Choice	☐ Child Coverage - $3000 Deductible ☐ Child Coverage - $6000 Deductible (Available to children age 18 or under)	☐ Individual - $3000 Deductible ☐ Individual - $6000 Deductible	

Please note: For Individual Coverage only, Page 2 is not required for a complete application.

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Primary Applicant First Name _____ MI _____ Last Name _____

Section 4 – Spouse / Dependent Information

Please complete only if your spouse and/or dependent children are applying for coverage.

SPOUSE First Name			MI	Last Name		
Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	I am a United States Citizen or Legal Resident ☐ Yes ☐ No		
Tobacco Use: ☐ No ☐ Yes - within the last 24 months ☐ Yes - more than 24 months ago				Height	Weight	Relationship to Applicant
DEPENDENT 1 First Name			MI	Last Name		
Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	I am a United States Citizen or Legal Resident ☐ Yes ☐ No		
Tobacco Use: ☐ No ☐ Yes - within the last 24 months ☐ Yes - more than 24 months ago				Height	Weight	Relationship to Applicant
DEPENDENT 2 First Name			MI	Last Name		
Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	I am a United States Citizen or Legal Resident ☐ Yes ☐ No		
Tobacco Use: ☐ No ☐ Yes - within the last 24 months ☐ Yes - more than 24 months ago				Height	Weight	Relationship to Applicant
DEPENDENT 3 First Name			MI	Last Name		
Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	I am a United States Citizen or Legal Resident ☐ Yes ☐ No		
Tobacco Use: ☐ No ☐ Yes - within the last 24 months ☐ Yes - more than 24 months ago				Height	Weight	Relationship to Applicant
DEPENDENT 4 First Name			MI	Last Name		
Date of Birth	Age	Gender ☐ Male ☐ Female	Social Security No.	I am a United States Citizen or Legal Resident ☐ Yes ☐ No		
Tobacco Use: ☐ No ☐ Yes - within the last 24 months ☐ Yes - more than 24 months ago				Height	Weight	Relationship to Applicant

Please answer the following questions if you are applying for any dependents other than your spouse:

☐ Yes ☐ No

1. Are all children for whom you are applying under the age of 26, and your (Please select all that apply):

☐ Biological children ☐ Adopted children ☐ Step-children

☐ Children placed with you in anticipation of adoption ☐ Children for whom you are legal guardian

If "No," please explain: _____

If there are court documents establishing guardianship or custody for any children for whom you are applying, please submit a copy of the final documents including but not limited to a court order establishing guardianship/custody.
This documentation must be submitted and approved prior to enrollment.

Primary Applicant First Name _____ MI _____ Last Name _____

Section 5 – General Information

Premiums

Quoted premiums are only an estimate. This application will be medically underwritten and Tennessee Rural Health Improvement Association ("Farm Bureau Health Plans" or "FBHP") may need to adjust your premium based on the information submitted on the application and any medical information submitted during the underwriting process.

In addition to being medically underwritten, FBHP coverages are age-rated. Rate adjustments will occur as the oldest person on the contract ages. General rate adjustments may also be necessary. You will be notified by letter thirty (30) days in advance of any rate adjustment.

Pre-Existing

THE PLANS LISTED ON THIS APPLICATION CONTAIN A PRE-EXISTING CONDITION WAITING PERIOD FOR ANY CONDITIONS THAT WERE IN EXISTENCE PRIOR TO THE COVERAGE'S EFFECTIVE DATE FOR ANYONE ON THE CONTRACT.

A pre-existing condition is defined in the contract as: "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

The pre-existing condition waiting period applies regardless of any previous or current coverage (unless you are a dependent eligible to transfer from an existing FBHP health plan). Any and all claims that are filed during this pre-existing condition waiting period will be reviewed by FBHP to verify they are not related to a pre-existing condition.

Please reference the Pre-Existing Acknowledgement under Section 7.

Section 6 – Health Questionnaire

Underwriting

All health questions must be answered. If any of the answers are "Yes", provide complete and accurate details in the space provided. The information provided on this application is used to determine eligibility for coverage for all individuals applying. Your full signature is required next to any changes you make to your responses to these questions. When answering the questions in this application, consider the health of all individuals applying for whom you are applying. Inaccurate or incomplete information provided on this application may constitute misrepresentation. Material misrepresentation could result in amended coverage or termination of coverage. Claims experience of any applicant currently or previously enrolled in a plan offered by FBHP or its subsidiaries, including TRH Health Insurance Company, may be considered during the underwriting process.

Medical Request(s)

If applying for any plan other than Enhanced Choice, the following medical records will be required to complete underwriting health assessment. For all plans, additional medical information may be needed and will be determined during the underwriting process:

For applicants ages 40 and older

- Height
- Weight
- Blood Pressure Reading
- Complete lipid panel to include: total cholesterol, HDL, LDL and triglycerides
- Glucose (sugar) results

All readings should be within the last 12 months.

For applicants ages 25 months and under

- All pediatric visits from birth to present to include the newborn metabolic screening results
- Immunization history or statement of intent to immunize

All persons age 40 and older and children age 25 months and under will automatically receive a request for medical information (details below). Applicants are encouraged to submit this information with the application to expedite the application process.
If medical information is not received by FBHP within thirty (30) days from the date of the request, your application for coverage will expire. To reapply for coverage, a new application will be required.

The applicant is responsible for requesting and obtaining medical information from providers and ensuring the medical information is received by FBHP. Any charges from providers associated with obtaining medical information must be paid by the applicant. The applicant is encouraged to keep a personal copy of all medical records submitted to FBHP. Once medical records are submitted to FBHP, the applicant must contact the FBHP Privacy Office to obtain a copy of medical records and may be a charged a fee for the return of medical records.

Primary Applicant First Name _____ MI _____ Last Name _____

Section 6 – Health Questionnaire Continued

List all medications, prescribed (including medical marijuana) and over-the-counter, and any type of injection(s), **within the last 12 months or that are currently being taken**, by you and/or any dependents for which you are applying.

Name of applicant	Name of medication(s)	What illness or condition is this medication treating?	Is medication currently being taken?	Date started	Date stopped
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

For any conditions or diseases listed below, during the past **seven (7) years**, have you or any dependent for whom you are applying
- received medical advice/treatment
- been medically diagnosed
- or experienced symptoms?

1.	Heart Attack, Valve Replacement, Stent Placement, Congestive Heart Failure, Cardiomyopathy, Pacemaker, Defibrillator, Any Aortic Abnormalities, Any Heart Defect Pending Future Repair	☐ Yes ☐ No
2.	Cancer, Leukemia, Tumor (Not Skin Cancer)	☐ Yes ☐ No
3.	Stroke, Transient Ischemic Attack (TIA)	☐ Yes ☐ No
4.	Kidney Disease, Kidney Failure, Renal Insufficiency (excluding kidney stone)	☐ Yes ☐ No
5.	Diabetes, Impaired Glucose Tolerance	☐ Yes ☐ No
6.	Lung Disease, Emphysema, Cystic Fibrosis, COPD	☐ Yes ☐ No
7.	Traumatic Brain Injury, Brain Aneurysm, Parkinson's, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Severe Cerebral Palsy, Multiple Sclerosis (MS), Muscular Dystrophy (MD), Alzheimer's, Dementia	☐ Yes ☐ No
8.	Liver Disease, Cirrhosis of the Liver, Hepatitis C	☐ Yes ☐ No
9.	Rheumatoid Arthritis, Psoriatic Arthritis, Lupus, Chronic Granulomatous Disease, AIDS, HIV, Addison's Disease, Sjogren's Syndrome, Crohn's Disease, Mixed Connective Tissue Disease, Myasthenia Gravis, Antiphospholipid Syndrome (APS)	☐ Yes ☐ No
10.	Gastric Bypass, Lap Band, Weight Loss Surgery of Any Kind	☐ Yes ☐ No
11.	Alcohol Abuse, Drug Use/Abuse, Drug Overdose, Used Illegal controlled drugs (prescription medication), marijuana, cocaine, heroin, methamphetamine, intravenous (IV) drugs, Suicide Attempt	☐ Yes ☐ No
12.	Bleeding Disorders, Hemophilia, Von Willebrand Disease	☐ Yes ☐ No
13.	Received transplants of any major organ such as kidney, liver, heart, or lung or taking any anti-rejection medication	☐ Yes ☐ No
14.	Any pending test, pending surgery or received abnormal test result(s) relating to any of the conditions/questions above	☐ Yes ☐ No

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_____ _____ _____

Primary Applicant First Name MI Last Name

If you are applying for Enhanced Choice Coverage, please skip to Section 7. If applying for any other plan, please continue.

Section 6 – Health Questionnaire Continued

For any conditions or diseases listed below, during the past **two (2) years**, have you or any dependent for whom you are applying
- received medical advice/treatment
- been medically diagnosed
- or experienced symptoms?

15.	Varicose Veins, Blood Clots, Deep Vein Thrombosis (DVT)	☐ Yes ☐ No
16.	Chest Pain or Angina	☐ Yes ☐ No
17.	High Cholesterol, High Triglycerides, High Lipid Results	☐ Yes ☐ No
18.	High Blood Pressure or Hypertension If Yes: Applicant Name _____Date of reading_____ What was last reading _____	☐ Yes ☐ No
19.	Other Heart or Circulatory Problems not previously listed	☐ Yes ☐ No
20.	Hiatal Hernia, Abdominal (Umbilical) Hernia, Ulcers	☐ Yes ☐ No
21.	Diverticulitis, Diverticulosis, Irritable Bowel Syndrome (IBS)	☐ Yes ☐ No
22.	Celiac Disease	☐ Yes ☐ No
23.	Other Stomach or Intestinal Problems not previously listed	☐ Yes ☐ No
24.	Esophageal Reflux, GERD (acid reflux)	☐ Yes ☐ No
25.	Concussion, Head Injury, Coma	☐ Yes ☐ No
26.	Headaches, Migraines	☐ Yes ☐ No
27.	Black-outs, Syncope or Fainting, Seizure(s), Convulsions	☐ Yes ☐ No
28.	Lyme Disease	☐ Yes ☐ No
29.	Anxiety, Depression, OCD, Panic Attacks, Bi-Polar, Chemical Imbalance, Mood Disorder, ADD, ADHD, Counseling/Therapy of any type	☐ Yes ☐ No
30.	Allergy Immunotherapy, Allergy Shots, Asthma, Reactive Airway Disease (RAD)	☐ Yes ☐ No
31.	Respiratory Syncytial Virus (RSV), Vaccinations for RSV or Tuberculosis	☐ Yes ☐ No
32.	Other problems associated with Throat, Eyes, Nose, Ears not previously listed	☐ Yes ☐ No
33.	Ear Tubes ☐ Currently in place ☐ No longer in place	☐ Yes ☐ No
34.	Bladder Infections, UTI, Urinary Pain, Urinary Incontinence, Kidney Infections	☐ Yes ☐ No
35.	Elevated Prostate Specific Antigen (PSA), Enlarged Prostate, Benign Prostatic Hypertrophy (BPH)	☐ Yes ☐ No
36.	Sexually Transmitted Disease (STD), Herpes Simplex Virus (HSV), Human Papilloma Virus (HPV), Genital Warts	☐ Yes ☐ No

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_____ _____ _____

Primary Applicant First Name MI Last Name

Section 6 – Health Questionnaire Continued

37.	Abnormal Mammogram, Ultrasound, Breast Exam, Breast Biopsy	☐ Yes ☐ No
38.	Abnormal Pap Smear, Ovarian Cyst	☐ Yes ☐ No
39.	Other Kidney, Bladder, Genitourinary problems not previously listed	☐ Yes ☐ No
40.	Goiter, Thyroid Nodule, Thyroid Cyst or any Gland Disorders, Thyroid, Pituitary	☐ Yes ☐ No
41.	Eczema, Rosacea, Psoriasis, Acne, Seborrheic Dermatitis, Keratosis, Abnormal Skin Lesions, Cyst, Skin Tumors	☐ Yes ☐ No
42.	Gout, Bone Spurs, Bunions, Plantar Fasciitis	☐ Yes ☐ No
43.	Carpal Tunnel Syndrome	☐ Yes ☐ No
44.	Temporal Mandibular Joint Dysfunction (TMJ)	☐ Yes ☐ No
45.	Chiropractic Treatment for: ☐ symptoms of pain or discomfort ☐ wellness or maintenance If yes, specify: Applicant Name(s)_____ Frequency: times per month_____ times per year _____	☐ Yes ☐ No
46.	Pain, Injury, or any other condition of the following ☐ Hip ☐ Right ☐ Left ☐ Both Applicant Name(s)_____ ☐ Knee ☐ Right ☐ Left ☐ Both Applicant Name(s)_____ ☐ Ankle ☐ Right ☐ Left ☐ Both Applicant Name(s)_____ ☐ Foot ☐ Right ☐ Left ☐ Both Applicant Name(s)_____ ☐ Shoulder ☐ Right ☐ Left ☐ Both Applicant Name(s)_____ ☐ Elbow ☐ Right ☐ Left ☐ Both Applicant Name(s)_____ ☐ Wrist ☐ Right ☐ Left ☐ Both Applicant Name(s)_____	☐ Yes ☐ No
47.	Physical therapy or steroid/cortisone injection(s) for any type of injury, inflammation or pain (excluding epidural injections)	☐ Yes ☐ No
48.	Sleep Apnea or sleeping problems	☐ Yes ☐ No
49.	Advised to have a sleep study	☐ Yes ☐ No
50.	Do you currently use or have you been advised to use a CPAP machine If currently using, please specify: ☐ Less than 12 months ☐ Over 12 months	☐ Yes ☐ No

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Primary Applicant First Name _____ MI _____ Last Name _____

Section 6 – Health Questionnaire Continued

For any conditions or diseases listed below, during the past **seven (7) years**, have you or any dependent for whom you are applying
- received medical advice/treatment
- been medically diagnosed
- or experienced symptoms?

51.	Ulcerative Colitis	☐ Yes ☐ No
52.	Stricture (narrowing) of Esophagus	☐ Yes ☐ No
53.	Kidney Stone, Nephrectomy (Surgical removal of Kidney)	☐ Yes ☐ No
54.	Interstitial Cystitis	☐ Yes ☐ No
55.	Endometriosis, Uterine Fibroids, Polycystic Ovaries	☐ Yes ☐ No
56.	Skin Cancer	☐ Yes ☐ No
57.	Osteoarthritis	☐ Yes ☐ No
58.	Fibromyalgia, Chronic Fatigue Syndrome	☐ Yes ☐ No
59.	Back, Spine, Neck Injury or Pain, Herniated Disc, Ruptured Disc, Bulging Disc, Sciatica, Scoliosis (curvature of spine), Degenerative Disc Disease	☐ Yes ☐ No
60.	Epidural Injection(s)	☐ Yes ☐ No
61.	Joint Replacement(s) for: ☐ Hip ☐ Knee ☐ Shoulder ☐ Other (please specify):_____	☐ Yes ☐ No
62.	Any other disease, disorder, medical condition, symptom, or treatment not previously provided on this application	☐ Yes ☐ No
63.	Have you or any dependent for whom you are applying ever had Internal, External fixations, screws, rods, plates, or prosthesis? If yes, Applicant Name(s):_____ Please specify: ☐ Arm ☐ Wrist ☐ Shoulder ☐ Knee ☐ Leg ☐ Foot ☐ Ankle ☐ Back	☐ Yes ☐ No
64.	Are any children you are applying for, under the age of 2 and born more than 2 months prematurely (32 weeks or less gestation)? If yes, Applicant Name(s)_____	☐ Yes ☐ No
65.	Within the last 12 months, has any applicant been advised to have a surgery/biopsy or testing that has not been completed (i.e. blood work, x-rays, CT, MRI, ultrasound, etc.)? If yes, complete the following: Applicant Names(s)_____ Specify pending surgery, biopsy or test _____ Explain why surgery, biopsy and/or test not completed:_____	☐ Yes ☐ No
66.	In the last 12 months, has any applicant been referred to a medical specialist of any kind (i.e. Cardiologist, Endocrinologist, Oncologist, Neurologist, Pulmonologist, Urologist, etc.)? If yes, complete the following: Applicant Names(s):_____ Type of Specialist: _____ Reason for Referral:_____ Final Diagnosis: _____ Doctor's Name:_____ Recovery Complete Date:_____	☐ Yes ☐ No
67.	In the last 12 months, has any applicant been seen in the Emergency Room or admitted to a hospital or any type of medical facility? If yes, complete the following: Applicant Name(s):_____ Reason:_____ Recovery Complete Date:_____	☐ Yes ☐ No
68.	Please list applicants who are age 18 and under, and not up to date on their immunizations according to the State's immunization schedule. Applicant's Name(s)_____	☐ Yes ☐ No

Farm Bureau HEALTH PLANS Tennessee

______________________ Primary Applicant First Name ______ MI ______________________ Last Name

If you answered "Yes" to any of the above questions listed in Section 6, please explain below and provide full details.			
Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			
Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			
Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			
Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			

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Primary Applicant First Name ____________ MI ____ Last Name ____________

If you answered "Yes" to any of the above questions listed in Section 6, please explain below and provide full details.

Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			
Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			
Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			
Question #	Applicant's name:		Diagnosis, condition or illness:
Duration (MM/YY)	Is the condition still present? ☐ Yes – Ongoing ☐ No- Resolved	Was surgery performed? ☐ Yes ☐ No	Doctor's name:
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:			
Please list all medications you take for this condition or illness in the medication section listed above question one.			

Primary Applicant First Name _____ MI _____ Last Name _____

Section 7 – Acknowledgements and Agreements

Newborn Waiver Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

- In the event any applicant or spouse of an applicant is pregnant and/or an expectant parent at the time of application, the newly born child will not have automatic coverage. The newborn child must meet the definition of an eligible dependent and FBHP medical underwriting guidelines. If application to cover the newborn child is made within 31 days of the date of birth and coverage is offered, the child's coverage will become effective on the date of birth. If adding a newly born child to an Enhanced Choice plan six months after the effective date of the original coverage, and application to cover the newborn child is made within 31 days of the date of birth, the child will not have to undergo medical underwriting. If the newborn child's application is made more than 31 days from the date of birth, and coverage is offered, the child's coverage will become effective on the next available effective date. The medical underwriting decision may result in a higher premium rate. If so, the coverage will be billed at the higher premium rate.

Pre-Existing Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

The following plans contain a pre-existing condition waiting period for any conditions that were in existence prior to the coverage's effective date for anyone on the contract as outlined below:

- **Major Medical** – 12-month pre-existing condition waiting period for anyone on the contract.
- **High Deductible (HSA-Qualified)** – 12-month pre-existing condition waiting period for anyone on the contract.
- **Core Choice and Enhanced Choice –** 6-month pre-existing condition waiting period for anyone on the contract. Additional waiting periods may apply including dental, vision, and other benefits as specified in the contract.
- **Child Coverage: Core Choice and Enhanced Choice** – 6-month pre-existing condition waiting period for anyone on the contract. Additional waiting periods may apply including dental, vision, and other benefits as specified in the contract.

HIPAA Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

This is not an application designed to accommodate the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA); therefore, portable/creditable coverage does not apply and no portion of my applicable pre-existing condition waiting period will be waived. In applying for this coverage, I understand and acknowledge that other health insurance issuers make available to individuals other health coverage plans which do not require medical underwriting and do not apply pre-existing condition limitations for individuals who have met certain prior creditable coverage requirements. I hereby acknowledge that although such portable coverage may be available to me/us, based on rates or other reasons, I have declined to apply for such coverage at this time.

PPACA Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

- The health benefits coverage for which I am applying through Tennessee Rural Health Improvement Association ("Farm Bureau Health Plans" or "FBHP") is not covered by the federal Patient Protection and Affordable Care Act ("PPACA") and does not meet the current PPACA requirements for individual health insurance.
- Under PPACA, individuals are required to purchase minimum essential coverage. Since the FBHP coverage for which I am applying is not covered by PPACA, and does not meet the PPACA requirements for individual health insurance, it is not considered minimum essential coverage.

Eligibility Acknowledgement: Please read carefully and initial in the space provided.

I understand and acknowledge — **Initial here:**

I must immediately notify FBHP when there is any change in the information submitted on this application concerning the eligibility for coverage of any dependent, including my spouse. Farm Bureau Health Plans reserves the right to request proof of continuing dependent eligibility at any time. In the event dependent eligibility cannot be determined based on the answers submitted on the application, additional information may be requested

For Reapplications Only. Under 65 Acknowledgement: If <u>reapplying</u> for other Farm Bureau Health Plans Coverage, please read and initial below.

I understand and acknowledge — **If reapplying, initial here:**

I am applying for new Farm Bureau Health Plans coverage which will require underwriting and could result in benefit exclusion riders for specified conditions. The new coverage will be subject to a waiting period for pre-existing conditions as well as a potential 9-month waiting period for maternity benefits on new family coverage (there are no maternity benefits on most individual coverage). If my application is approved and I accept the new coverage, my existing coverage with Farm Bureau Health Plans will be cancelled by my written request, and will be replaced by the new coverage. ***The new coverage may not provide benefits for illnesses that may have been covered under your existing coverage.*** The above information has been sufficiently explained to me and in consideration of the issuance of said new coverage, I agree as set forth above.

Primary Applicant First Name | MI | Last Name

Section 7 – Acknowledgements and Agreements (continued)

IMPORTANT: The approval of this application is subject to medical underwriting guidelines. If you have current coverage, do not cancel your current coverage until you have been issued coverage by FBHP and upon review, agree to accept the rate, terms and conditions of the contract.
If approved for coverage, you will be mailed a billing statement for the initial amount due. This billed amount will need to be paid by the due date. Once the billed amount has been paid, the automatic withdrawal from your bank account will begin on or after the 1st of the following month. You consent to electronic communications being provided in connection with your application for coverage, including but not limited to, your application and contract. Electronic copies of your contract may be obtained by visiting https://fbhealthplans.com/fbhp-welcome, or you may obtain a paper copy at any time by contacting 877-874-8323. Your FBHP Plan identification card(s) should arrive within a few days of the billing. Please review both the identification card(s) and the contract carefully, as they contain important information. You will have 30 days from the date you receive your contract to decide if you want to continue the coverage. FBHP is entitled to rely solely 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 identification 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 FBHP program.

Please Read Carefully and Sign the Appropriate Acknowledgement Section Below

I hereby authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm having any information necessary to determine the eligibility of each person for whom application is made, to give to FBHP or its affiliates all such information for the purposes of underwriting, premium determination, and/or claims administration. I (or my personal representative) may request a copy of this authorization.

I understand the information in this application and any information obtained with this authorization will be used by FBHP to determine eligibility for coverage and that coverage and rates will be affected by this information. Rates resulting from an underwriting determination more than 30 days in advance of the effective date could be subject to change.

If I am not already a member, I hereby make application for membership in the Tennessee Farm Bureau/FBHP. I understand this membership entitles me to apply for the services offered by FBHP 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 for myself, my spouse and all children for whom I am applying. I understand it is a crime to knowingly provide false, incomplete or misleading information to FBHP for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of coverage.

Acknowledgement for Individual Adult or Family Coverage

All individuals for whom application is made who are 18 years of age or older must sign and date the application, acknowledging their understanding of and agreement to the conditions listed above.

Applicant Signature | **Today's Date** | **Spouse Signature** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Dependent Signature (age 18 and older) | **Dependent Printed Name (age 18 and older)** | **Today's Date**

Acknowledgement for Child Coverage (Age 18 and Under)

I declare the foregoing statements provided by me in this application in its entirety are true, correct and complete for the child for whom I am applying. I understand that if coverage is issued, I am the only person allowed to sign for changes to or cancellation of this coverage.

Signature of Subscriber Parent, Step-Parent or Legal Guardian | **Relationship** | **Today's Date**

Print Name of Subscriber Parent, Step-Parent or Legal Guardian | **Social Security Number**

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete for the child for whom application is made. I understand that if coverage is issued, I cannot sign for changes to or cancellation of this coverage. I understand as parent or legal guardian of the child, I may, depending upon the age of the child, have the right to obtain information about this child's application and coverage if issued.

Signature of Non- Subscriber Parent, Step-Parent or Legal Guardian | **Relationship** | **Today's Date**

Print Name of Non-Subscriber Parent, Step-Parent or Legal Guardian

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.

FARM BUREAU HEALTH PLANS
TRADITIONAL MEMBERSHIP HEALTH PLAN
APPLICATION CHECKLIST

☐ **Section1 – Primary Applicant Information**

- Complete with current information for you or the child for whom you are applying.

☐ **Section 2 – Application Information**

- Select the type of application.

☐ **Section 3 – Coverage Options**

- Choose one (1) plan and (1) deductible option.

☐ **Section 4 – Spouse / Dependent Information**

- Complete with current information and answer all questions regarding your spouse and all dependent children for whom you are applying (if applicable).

☐ **Section 5 – General Information**

- Read carefully as this section contains important information.

☐ **Section 6 – Health Questionnaire**

- List all medications for everyone applying, as requested. If necessary, please add a separate sheet with additional information.
- Individually mark ALL QUESTIONS "Yes" or "No" for everyone applying for coverage.
- List detailed information for every health question answered "Yes". Providing detail of recovery dates and doctor's names may decrease the likelihood of more medical information being requested. If necessary, please add a separate sheet with additional information.

☐ **Section 7- Acknowledgements and Agreements**

- Read and initial each area as requested to acknowledge your understanding. If applying for individual adult coverage or family coverage, complete the Acknowledgement for Individual Adult or Family Coverage box. If applying for Core Choice Child Coverage or Enhanced Choice Child Coverage, complete the Acknowledgement for Child Coverage (Age 19 and Under) box.
- 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.

☐ **TN Farm Bureau Membership**

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

☐ **Return to Farm Bureau Health Plans**

- Mail (completed FBHP Application, Bank Draft Authorization, and Farm Bureau Membership Application with EFT Agreement, if applicable) to P.O. Box 313, Columbia, TN 38402-0313, email to appsforms@fbhp.com or deliver to your local Farm Bureau office. Go to fbhealthplans.com to locate an office near you.

FBHP's toll-free number is 1-877-874-8323, 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.

Bank Draft Authorization Form
For Under 65 and Dental Plans Only

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 10 days prior to the draft date in order to be effective for the next draft.
- **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

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

☐ Check this box if the ***Primary Name on Bank Account*** is not the same as the ***Primary Applicant*** for coverage.
This serves as authorization for payments to be made from the bank account entered below.

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 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 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**

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