Indiana Farm Bureau Health Plans

Indiana Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 888-964-0854
Fax: 931-560-4278
billingforms@fbhpservices.com

Alternative Plan Selection | Transfer | Change Form

General Information

Upon completion, please submit to address, fax or email above. | **Original ID Number:**

Section 1 Subscriber Information

First Name	MI	Last Name
Date of Birth / Age	Gender ☐ Male ☐ Female	Social Security Number
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____		Date of Marriage/Divorce
Mailing Address If this is a new address, check this box: ☐		
City / State / Zip		IN Farm Bureau Membership Number
Phone Number	Email Address (by providing your email address, you agree to receive electronic communications from IFBHP)	

Section 2 Reason for Change

☐ **Alternative Plan Option** ☐ **Transfer Option**

- List the plan/deductible below.
- List any previously approved dependents you wish to have on your plan in Section

Plan Name: **Deductible:** ☐ **Individual Coverage** ☐ **Family Coverage**

By signing the form below, I understand and acknowledge:

- This acceptance form shall supplement my previously submitted Indiana Farm Bureau Health Plans Traditional Membership Application, and all terms of such are incorporated within.
- IFBHP 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.
- The offer is time sensitive and must be returned to IFBHP within 30 days of the date of the offer letter or the offer of coverage will be revoked.
- I have fully read, understand, and agree to all terms and conditions and hereby accept the designated plan listed above for healthcare coverage.

☐ **Name Change**	Change name to / Former Name
☐ **Request Plan Effective Date Change**	
☐ **Change my Coverage**	(NOTE: Once you change coverage, you will not be able to go back to the previous plan unless you re-apply) Plan Name: Deductible:
☐ **Dependent Change**	Maternity Benefits | Individual Coverage: No maternity benefits provided, unless Classic Plan. Family Coverage: Maternity benefits available after coverage has been in effect for nine consecutive months. Additional documentation may be required if adding or deleting spouse/dependent(s). List date of marriage or divorce if applicable.
	☐ Change my coverage from individual to family / ☐ Change my coverage from family to individual
	☐ Add the following spouse/dependent(s) / ☐ Delete the following spouse/dependent(s)

Section 3 Dependents (For Accepting Underwriting Option or Dependent Change Only)

DEPENDENT 1 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE): _____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 2 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE): _____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 3 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE): _____		Date of Marriage/Divorce	Relationship to Subscriber

Section 4 Acknowledgement

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.

Subscriber Signature **Today's Date**

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Bank Draft Authorization Form

Indiana Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 888-964-0854
Billing Fax: 931-560-4278
billingforms@fbhpservices.com

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 Indiana 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 (for existing Subscriber)	Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number

Banking Information

Authorization Type

☐ 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 Indiana 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 Indiana 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, Indiana 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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