



# Medicare Supplement Plan Change Form

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	
Social Security Number		Date of Birth	Subscriber ID Number	County/Subgroup
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)

<input type="checkbox"/> Drop	I understand and acknowledge: I am requesting a plan with less benefits than the plan I currently have. To see if I qualify for the lowest premium available for Plan G, I must answer all health questions below and be approved by FBHP. By not answering the questions, I will receive the Plan G Drop Rate.						
<input type="checkbox"/> 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):							
<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan G	<input type="checkbox"/> Plan M	<input type="checkbox"/> Plan N

## Health Questions – If upgrading coverage or requesting the lower premium option for Plan G, 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 or the lower premium option for Plan G 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:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. Heart Attack or Congestive Heart Failure?	If "Yes," when (date of onset)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. Cancer (Not Skin Cancer)?	If "Yes," when (date of onset)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. Stroke or Trans Ischemic Attack (TIA)?	If "Yes," when (date of onset)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. Kidney Failure or Disease?	If "Yes," when (date of onset)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. Diabetes?	If "Yes," when (date of onset)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6. Parkinson's Disease?	If "Yes," when (date of onset)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	7. Multiple Sclerosis or Lou Gehrig's Disease (ALS)?	If "Yes," when (date of onset)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Muscular Dystrophy?	If "Yes," when (date of onset)?

## 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
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**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 \_\_\_\_\_