Kansas Farm Bureau® Health Plans

Cancellation Form

Farm Bureau Health Plans
PO Box 313
Columbia, TN 38402-0313
Phone: 877-874-8323
billingforms@fbhp.com

County Office or FBHP Agent Use Only

Subgroup	County	Branch

General Information

Upon completion, please submit it to address or email above.

Subscriber Information

First Name	MI	Last Name	Date of Birth

Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number

Cancellation Information

☐ Cancel my Coverage

Please select a termination reason in the columns on the right.

Requested Date of Change (for existing Subscribers):

☐ Employer Coverage
☐ Other Individual Coverage
☐ Marketplace/Exchange
New Insurance Company:
_____
☐ Affordability
- ☐ Rate Increase
- ☐ Personal Reasons
- ☐ Age Band Increase

☐ Aging Off
☐ Combining Policies

☐ Dissatisfied
- ☐ FBHP poor customer service
- ☐ UMR poor customer service
- ☐ Delta Dental poor customer service
- ☐ Provider network
- ☐ Pre-existing waiting period concerns
- ☐ Benefit exclusion
- ☐ Decline of dependent
- ☐ Rate

☐ Divorce
☐ Change/Transfer Option

☐ Cancel Coverage due to Death

If no estate, please attach a copy of the executor's valid driver's license and subscriber's death certificate.

Subscriber Deceased Date		
Executor Name	Executor Phone No.	
Executor Mailing Address		
City	State	Zip Code

Coverage Termination

You, as a Subscriber, can cancel the coverage for any reason by giving 10 days' written notice to Farm Bureau Health Plans. Your coverage will terminate the following paid-to-date.

Please note: once a cancellation is processed, it cannot be revoked. In order to obtain new coverage, a new application is needed, medical underwriting for approval and pre-existing condition waiting periods will apply.

If your coverage terminates because of your death and there are no dependents covered, coverage ends on the date of death, and your estate is entitled to a refund of any unused premiums.

If you are on a monthly bank draft, you have the option to stop payment at your bank, provided you present your bank with the proper account information and exact bank draft amount.

Farm Bureau Health Plans may also cancel this coverage. You will be given 30 days' written notice. Such notice will be binding once mailed to you at the current address shown in our records. It is your responsibility to maintain your current address on file with Farm Bureau Health Plans and the Administrator at all times.

Subscriber/Executor /Authorized 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.