



Kansas Farm Bureau Health Plans
 PO Box 1424
 Columbia, TN 38402-1424
 Phone: 833-282-5928
 Fax: 931-560-4278
 billingforms@fbhealthplans.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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Tobacco Use: <input type="checkbox"/> No <input type="checkbox"/> Yes – within the last 24 months <input type="checkbox"/> Yes – more than 24 months ago (DATE): _____		Date of Marriage/Divorce	
Mailing Address If this is a new address, check this box: <input type="checkbox"/>			
City	State	Zip	KS Farm Bureau Membership Number
Phone Number	Email Address (by providing your email address, you agree to receive electronic communications from KFBHP)		
Section 2 Reason for Change			
<input type="checkbox"/> Alternative Plan Option <input type="checkbox"/> Transfer Option - List the plan/deductible below. - List any previously approved dependents you wish to have on your plan in Section 3			
Plan Name:		Deductible:	<input type="checkbox"/> Individual Coverage <input type="checkbox"/> Family Coverage
By signing the form below, I understand and acknowledge:			
- This acceptance form shall supplement my previously submitted Kansas Farm Bureau Health Plans Traditional Membership Application, and all terms of such are incorporated within. - KFBHP 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 KFBHP 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.			
<input type="checkbox"/> Name Change	Change name to _____ Former Name _____		
<input type="checkbox"/> Request Plan Effective Date Change			
<input type="checkbox"/> 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: _____		
<input type="checkbox"/> 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.		
	<input type="checkbox"/> Change my coverage from individual to family	<input type="checkbox"/> Change my coverage from family to individual	
	<input type="checkbox"/> Add the following spouse/dependent(s)	<input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth/Date of Death Age
Tobacco Use: <input type="checkbox"/> No <input type="checkbox"/> Yes – within the last 24 months <input type="checkbox"/> Yes – more than 24 months ago (DATE): _____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 2 First Name		MI	Last Name
Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth/Date of Death Age
Tobacco Use: <input type="checkbox"/> No <input type="checkbox"/> Yes – within the last 24 months <input type="checkbox"/> Yes – more than 24 months ago (DATE): _____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 3 First Name		MI	Last Name
Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth/Date of Death Age
Tobacco Use: <input type="checkbox"/> No <input type="checkbox"/> Yes – within the last 24 months <input type="checkbox"/> Yes – more than 24 months ago (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

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 Kansas 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 <input type="checkbox"/> New Applicant <input type="checkbox"/> Existing Subscriber	Requested Date of Change (for existing Subscribers)
Please complete or attach voided check. Account Type: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	
<input type="checkbox"/> 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 Kansas 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 Kansas 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, Kansas 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.

Alternative Plan Selection/Transfer/Change Form Instructions

****All changes are due 10 days prior to the paid to date***

- **Alternative Plan Option**
 - Member(s) does not qualify for the plan applied for, but offered an alternative option of coverage
Note: If Member was a dependent on the original application, a Bank Draft form is required.
- **Transfer Option**
 - Member(s) want to split a contract once they are approved for an Offer of Coverage
 - Member(s) wishes to transfer off an existing plan to their own coverage
 - Turning 26 member transfer from parent plan to individual plan
 - Child Policy member Turning 19 should complete to transfer from child plan to Adult plan
 - Divorce
Note: The transfer coverage of an existing paid plan will need to be “like coverage” or an available plan drop option, if available.
Note: A Bank Draft form is required for above scenarios
- **Name Change**
 - Change name to married name, divorced name, legal name
 - Change name to correct name due to error made by member on application
 - Information needed: Verification of name (driver's license or birth certificate)
- **Requested Plan Effective Date Change**
 - Member wishes to change plan effective date (if the 1st premium has not been paid)
Note: The signature date of the application must be within 60 days of the effective date.
If outside the 60 days contact the toll free number on the Alternative Plan Selection form.
- **Change My Coverage**
 - Member wishes to change plan before the initial payment is made or to a possible plan drop option if the initial payment has already been paid
Note: If the member wishes to change to a plan that is not a plan drop option to the current plan and initial payment has been made, a new online application is to be completed.
- **Dependent Change for Health Plan**
 - Member wishes to add a dependent(s) to contract that does not require medical underwriting
Note: For most add dependent(s) a paper application is required and health questions answered for that dependent(s).
Note: If adding a newborn please call the toll free number listed on the Alternative Plan Selection form.
 - Member wishes to delete a dependent(s) from contract
- **Dependent Change for Dental/Vision Plan**
 - Member wishes to add a dependent(s) to contract
 - Member wishes to delete a dependent(s) from contract