KANSAS FARM BUREAU® Health Plans
Insured By Members Health Insurance Company

Kansas Farm Bureau Health Plans
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Medicare Supplement Plan ChangeForm

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 KFBHP)			

Change in Coverage (Medicare Replacement Form Required)

☐ Drop	I understand and acknowledge: **I am requesting a plan with less benefits than the plan I currently have.**
☐ 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 KFBHP.**

I wish to change my current Medicare Supplement plan to (select one):

☐ Plan A	☐ Plan D	☐ Plan G	☐ Plan N

Health Questions – If *upgrading* coverage or requesting the lower premium option for Plan G, the following questions are required to be completed.

Kansas 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 KFBHP coverage may be used in this process.

In the last five (5) years, have you been treated for any of the following medical conditions:

☐ Yes	☐ No	1. Heart Attack or Congestive Heart Failure?	If “Yes,” when (date of onset)?
☐ Yes	☐ No	2. Cancer (Not Skin Cancer)?	If “Yes,” when (date of onset)?
☐ Yes	☐ No	3. Stroke or Trans Ischemic Attack (TIA)?	If “Yes,” when (date of onset)?
☐ Yes	☐ No	4. Kidney Failure or Disease?	If “Yes,” when (date of onset)?
☐ Yes	☐ No	5. Diabetes?	If “Yes,” when (date of onset)?
☐ Yes	☐ No	6. Parkinson's Disease?	If “Yes,” when (date of onset)?
☐ Yes	☐ No	7. Multiple Sclerosis or Lou Gehrig's Disease (ALS)?	If “Yes,” when (date of onset)?
☐ Yes	☐ 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

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.