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

Kansas Farm Bureau Health Plans
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COVERAGE CHANGE FORM

☐ **ID No.** _____

Subscriber Name	**Subscriber's Date of Birth**
Group No.	**Subgroup**

1. ☐ Change Name To: | **Former Name:**

2. ☐ Change my mailing address to the following:

Street or PO Box:_____

City:_____

State:_____ **Zip Code:**_____

Daytime phone number: (_____) _____

3. ☐ Change my coverage to:

Please note – once a change to benefits has been processed, it cannot be revoked. In order to regain benefits, medical underwriting for approval and pre-existing condition waiting periods will apply.

Subscriber Signature X _____ **Date:** _____

It is a crime to knowingly provide false, incomplete or misleading information for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.