FARM BUREAU HEALTH PLANS MICHIGAN
Insured by Members Health Insurance Company

Michigan Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 833-282-5975
Billing Fax: 931-560-4278
BillingForms@fbhealthplans.com

Medicare Supplement Plan Change Form

General Information

First Name	MI	Last Name	
Social Security Number	Date of Birth	Subscriber ID Number	Gender ☐ Female ☐ Male
Mailing Address	City	State	Zip Code
Phone No.	Email Address (by providing your email address, you agree to receive electronic communications from MFBHP)		

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 MFBHP.**

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, the following questions are required to be completed.

Michigan 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 based on our current underwriting standards. Claims experience from any previous MFBHP 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?
☐ Yes ☐ No	2. Cancer (Not Skin Cancer)?	If "Yes," when?
☐ Yes ☐ No	3. Stroke or Trans Ischemic Attack (TIA)?	If "Yes," when?
☐ Yes ☐ No	4. Kidney Failure or Chronic Kidney Disease?	If "Yes," when?
☐ Yes ☐ No	5. Diabetes?	If "Yes," when?
☐ Yes ☐ No	6. Parkinson's Disease?	If "Yes," when?
☐ Yes ☐ No	7. Multiple Sclerosis or Lou Gehrig's Disease (ALS)?	If "Yes," when?
☐ Yes ☐ No	8. Muscular Dystrophy?	If "Yes," when?
☐ Yes ☐ No	9. Emphysema or COPD?	If "Yes," when?
☐ Yes ☐ No	10. Alzheimer's Disease or Dementia?	If "Yes," when?
☐ Yes ☐ No	11. Cirrhosis of the liver?	If "Yes," when?
☐ Yes ☐ No	12. Huntingdon's disease?	If "Yes," when?

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.

FARM BUREAU HEALTH PLANS®
MICHIGAN
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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Home Office: [P.O. Box 1424, Columbia, TN 38402-1424, 1-833-282-5975]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your enrollment application, you intend to terminate existing Medicare Supplement or Medicare Advantage Insurance and replace it with a Certificate to be issued by Farm Bureau Health Plans of Michigan. Your new Certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the Certificate.

You should review this new coverage carefully. Compare it with all disability and other health coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement Insurance is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage Insurance.

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 Insurance will not duplicate your existing Medicare Supplement Insurance or, if applicable, Medicare Advantage Insurance because you intend to terminate your existing Medicare Supplement Insurance or leave your Medicare Advantage Insurance. The replacement Certificate 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) State law provides that your replacement Certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new Certificate to the extent such time was spent (depleted) under the original policy.

(2) 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 enrollment application concerning your medical and health history. Failure to include all material medical information on an enrollment application may provide a basis for the company to deny any future claims and to refund your premium as though your Certificate had never been in force. After the enrollment 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 Certificate and are sure that you want to keep it.

Applicant's Signature: _____ Date: _____

Applicant's Printed Name: _____ Address: _____

_____

Policy, Certificate, or Contract Number being Replaced: _____