SOUTH DAKOTA FARM BUREAU® Health Plans

South Dakota Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 833-480-2188
Fax: 931-560-4278
billingforms@fbhp.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 ☐ Male ☐ Female	Social Security Number
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____			Date of Marriage/Divorce
Mailing Address If this is a new address, check this box: ☐			
City	State	Zip	SD Farm Bureau Membership Number
Phone Number	Email Address (by providing your email address, you agree to receive electronic communications from SDFBHP)		

Section 2 Reason for Change

☐ **Alternative Plan Option** ☐ **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:** ☐ **Individual Coverage** ☐ **Family Coverage**

By signing the form below, I understand and acknowledge:
- This acceptance form shall supplement my previously submitted South Dakota Farm Bureau Health Plans Traditional Membership Application, and all terms of such are incorporated within.
- SDFBHP 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 SDFBHP 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.

☐ **Name Change**	Change name to	Former Name
☐ **Request Plan Effective Date Change**		
☐ **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:
☐ **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.	
	☐ Change my coverage from individual to family	☐ Change my coverage from family to individual
	☐ Add the following spouse/dependent(s)	☐ 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 ☐ Male ☐ Female	Date of Birth/ Death	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 2 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth/ Death	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE):_____		Date of Marriage/Divorce	Relationship to Subscriber
DEPENDENT 3 First Name	MI	Last Name	
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth/ Death	Age
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (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.
- Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.
- **Cancellation**- the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to South Dakota 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

Requested Monthly Draft Date	Health Plan Subscriber ID Number
☐ 1st of each month ☐ 15th of each month	

Banking Information

Authorization Type	Requested Date of Change (for existing Subscribers)
☐ New Applicant ☐ Existing Subscriber	

Please complete or attach voided check.

Account Type: ☐ Checking Account ☐ Savings Account

Name of Financial Institution

Address of Financial Institution

Routing Number	Account Number

Authorization

I hereby authorize South Dakota Farm Bureau Health Plans to initiate debit entries from the account indicated above for the monthly payment of health 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 South Dakota Farm Bureau Health Plans in writing at least 10 days prior to the next draft date. I further agree that should a debit be dishonored, whether with or without a cause and whether intentionally or inadvertently, South Dakota Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Applicant/Subscriber Printed Name		**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