FARM BUREAU HEALTH PLAN

Individual Health Plan Contract Change Form
(For Farm Bureau Health Plan)

Instructions: Use a ballpoint pen to complete the form and follow guidelines listed below:

GUIDELINES

Complete checked section if you are using this form to:	A	B	C	D	E	F
Remove the policyholder	✓	✓	✓	✓		✓
Remove a member	✓	✓				✓
Remove a member and member moving to new policy due to a qualifying event	✓	✓	✓	✓		✓
Reinstatement for returning active military duty individuals	✓	✓				✓
Cancel entire policy	✓				✓	✓

To update billing options, please complete the last page (Automatic Withdrawal Authorization Form, M-9319699) of this form.

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member for timely processing. Further review may be necessary if an SSN or TIN is not provided.

Farm Bureau Member Number	Farm Bureau Office Mail Code Number (if applicable)

Please check box to left of item(s) you are changing and provide complete information.

B. CONTRACT CHANGES

Removing Policyholder

- ☐ Active military duty (TRICARE) (Please provide copy of military papers, indicating date of entry.)
- ☐ Divorce/annulment/legal separation
- ☐ Death
- ☐ Medicare, Medicaid or VA enrolled
- ☐ Obtain employer group coverage

List date of event: _____/_____/_____

Removing Member

- ☐ Active military duty (TRICARE) (Please provide copy of military papers, indicating date of entry.)
- ☐ Divorce/annulment/legal separation
- ☐ Death
- ☐ Medicare, Medicaid or VA enrolled
- ☐ Obtain employer group coverage
- ☐ Other, Specify: _____

List date of event: _____/_____/_____ **List name(s) of member(s) removed:** _____

Cancellation Date

Cancellation date will be as applicable:

- End of the month in which the death occurred if the signature on the change form is within 60 days of the event. If the change form was signed more than 60 days after death, the cancellation date will be the end of the month in which the change form was signed.
- All other events will be the end of the month preceding the event if the signatue on the change form is within 60 days of the event. If the change form was signed more than 60 days after the event, cancellation date will be the end of the month in which the change form was signed.

If removing a member without an event, your cancellation date will be the end of the month of your signature date on this change form.

Reinstate

☐ Return from active military duty (if reinstated within one year of policy suspension)

List date of event: _____/_____/_____ **List name(s) of member(s) reinstated:** _____

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

C. NEW POLICYHOLDER INFORMATION

New Policyholder Name *(First, Middle, Last)*		Social Security Number/Tax Identification Number			
Mailing Address, Street	Bldg. Name/No., Apt. No.	PO Box	City	State	ZIP
Provide name of county in which policyholder resides:					
Billing Address, Street (if different from Mailing Address)	Bldg. Name/No., Apt. No.	PO Box	City	State	ZIP
Preferred Phone Number ( )	Email Address:				
Farm Bureau Member Number		Farm Bureau Office Mail Code Number (if applicable)			

D. EXISTING MEMBERS TO BE CONVERTED TO NEW CONTRACT

Name (First, Last)	Relationship	Date of Birth	Social Security Number / Tax Identification Number	Gender
Applicant	Self			☐ Male ☐ Female
Spouse	Spouse			☐ Male ☐ Female
Dependent 1				☐ Male ☐ Female
Dependent 2				☐ Male ☐ Female

E. CANCELLATION OF ENTIRE POLICY

I am requesting cancellation of my entire policy effective _____/ 1 /_____. I understand Farm Bureau Health Benefit Plan does not allow cancellation on odd dates, and the earliest available cancellation date is the first day of the month after Wellmark Administrators, Inc.'s receipt of this request. My coverage will continue through the last day of the month in which I notify Wellmark Administrators, Inc. to cancel. To cancel automatic account withdrawal, Wellmark Administrators, Inc. must receive this request by the 10th of the month prior to my next scheduled withdrawal. To otherwise stop payment, I will notify my bank. I will be responsible for any associated fees from my bank. To update automatic withdrawal options please complete an Automatic Withdrawal Authorization form (M-9319699) at the end of this form.

F. AUTHORIZATION, CERTIFICATION AND SIGNATURE

I certify that I have carefully and fully read the Authorization and Certification language appearing below.

I certify that I am legally authorized to make changes in coverage for myself and on behalf of all other persons named on my current policy and in this form, and I further have confirmed with all persons named on my current policy and on this form that my signature is binding to change coverage.

If I am electing Farm Bureau Health Benefit Plan, I understand that as a condition of eligibility for benefits under the coverage specified in this form, each person to be covered on one of these Health Plan Options must maintain his/her residency in an Iowa county. Failure to maintain such residency by any person named in this application will give Farm Bureau Health Benefit Plan the right to terminate the coverage specified in this application for that person not maintaining residency by giving that person not less than thirty (30) days notice in advance of termination of coverage and benefits will be denied unless the medical services are related to emergency services or an accidental injury.

The statements and answers set forth in this form are full, true, and correct. I have consulted with each other person named in this form to confirm that information about him/her is full, true, and correct. I understand that Farm Bureau Health Benefit Plan will rely on the completeness and truthfulness of the information given in the statements made in this form or by telephone or in writing to WAI, and that, if I performed an act, practice, or omission that constitutes fraud or I have made an intentional misrepresentation of material fact in this form, Farm Bureau Health Benefit Plan will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

Providing Social Security Numbers or Tax Identification Numbers
In order for WAI to report my coverage status to the state and/or federal government, I understand I must provide to WAI my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires that WAI report this information using the Social Security number or tax identification number of the plan member and each dependent. If WAI does not have Social Security or tax identification numbers, I understand that WAI will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided the Social Security numbers or tax identification numbers to WAI for all members covered under my coverage, I will contact WAI by calling the Customer Service number on my ID card. I understand if I do not provide the Social Security numbers or taxpayer identification numbers to WAI for this purpose, I may be subject to a monetary penalty per violation imposed by the Internal Revenue Service.

Coverage Renewability

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

F. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

I understand that coverage is automatically renewed by payment of my premium and applicable fees in advance; that a grace period of 31 days will be granted for the payment of each premium and fee due after the first premium and fees; and that, during this grace period, my policy will continue in force.

I understand that Farm Bureau Health Benefit Plan may terminate my policy if:

- I fail to pay my premium and service fee when due; or
- I fraudulently use my policy or make an intentional misrepresentation of a material fact under the terms of my policy; or
- I become ineligible for coverage under this policy; or
- Farm Bureau Health Benefit Plan decides to terminate coverage of similar policies by giving written notice prior to termination. In the event Farm Bureau Health Benefit Plan terminates individual policies of the same coverage, I will be allowed to transfer to the offered replacement policy.
- I change my residence from the geographic service area served by Farm Bureau Health Benefit Plan.

Consent to Receive Information Electronically

By signing this application, agreeing to these terms, or providing my email address, and confirming electronically, I provide my consent to Farm Bureau Health Benefit Plan and WAI to deliver important notices and information about my health plan and coverage electronically. My consent applies to notices and documents relating to my Farm Bureau health coverage administered by WAI, including but not limited to:

Notifications of eligibility:

- Explanation of Benefits;
- Disclosures and notices;
- Notices of cancellation, non-renewal or termination (which may also be provided by mail);
- Benefits policy documents, amendments, riders or endorsements;
- Responses to communications from you;
- Appeals correspondence;
- Billing and payment notices; and
- Other important information

I understand that agreeing to receive information electronically is a condition of enrolling in the Farm Bureau Health Benefit Plan.

In order to access, view, and retain documents electronically, I understand I must have access to a computer or other device capable of accessing the internet with an internet web browser, email or web service capabilities, the ability to receive and review attachments to emails, and software which permits me to receive and access Portable Document Format (PDF) files. Free software to view PDF files is available from: http://get.adobe.com/reader/ External Site. By providing this consent, I confirm that I have or have access to the hardware and software identified above necessary to receive and review electronic records, and that I have an active email account with the ability to receive and access emails and email attachments in the formats described.

Farm Bureau Health Benefit Plan and its administrator WAI are not responsible for any unauthorized access by third parties to information provided electronically, including, without limitation, any direct, indirect, special, incidental, or consequential damages resulting from such unauthorized access. WAI also is not responsible for delays in transmission of notices and documents.

Consent to Receive Calls and Text Messages

By providing us your home or mobile phone number you give Farm Bureau Health Benefit Plan and WAI permission to contact you at that number about all of your Farm Bureau Health Benefit Plan and WAI accounts. Your consent allows us to use text massaging, artificial or pre-recorded voice messages, and automatic dialing technology for informational or account servicing calls but not for telemarketing or sales calls. It may include contact from companies working on our behalf to service your account. Message and data rates may apply. You may contact us any time to change your contact preferences.

Existing Policyholder Signature X _____ Date _____/_____/_____

New Policyholder Signature X _____ Date _____/_____/_____

If applicant is a minor, please sign below.

Parent/Legal Guardian/POA Printed Name _____

Parent/Legal Guardian/POA Signature X_____ Date _____/_____/_____
(If legal guardian please provide legal guardianship documentation. If POA please provide POA documentation)

Agent Signature, if applicable X_____ Agent No. __ __ __ __ __ __ __ __

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

F. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

This completed contract change form must be received within 15 days of your signature date.

Send completed form to:
Wellmark Administrators, Inc.
Mail Station 3W190
PO Box 14527
Des Moines, IA 50306-3527
OR
Fax to: 515-376-9045
OR
E-mail to: updatesindividualmembership@wellmark.com

Note: If you are a new policyholder or updating billing options, you must complete the next page of this form, Automatic Withdrawal Authorization Form (M-9319699), and submit within 15 days of your signature date.

FARM BUREAU HEALTH PLAN

Automatic Withdrawal Authorization Form (For Farm Bureau Health Plan)

Policyholder Name_____ **Effective Date**_____/_____/_____

Policyholder SSN or Member ID_____ **Policyholder Date of Birth**_____/_____/_____

☐ New Enrollment ☒ Update to an existing policy

☐ **Automatic account withdrawal from policyholder's account**
☒ **Automatic account withdrawal from account other than the policyholder's**

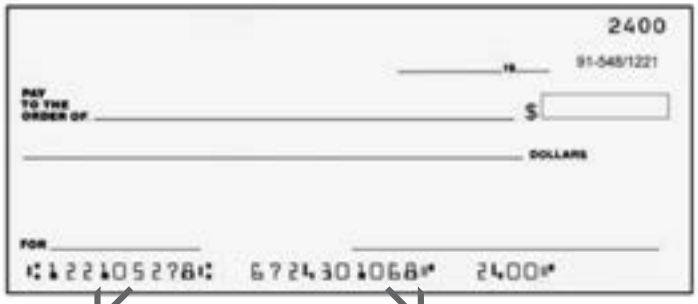
Premiums will be withdrawn monthly:

☐ First of the month ☒ Fifth of the month

Select Bank Account Type:

☐ Checking
☒ Savings

Provide your Routing and Account Numbers here:



9-Digit Bank Routing Number	Bank Account Number

Electronic Funds Transfer Automatic Payment Authorization

By providing the bank account information shown, I certify that I am the Bank Account Holder and I authorize Farm Bureau Health Plan or its administrator Wellmark, to make automatic withdrawals from the account in the amount of the periodic payment and related fees, if applicable, as they may be adjusted from time to time. This authorization for automatic withdrawals shall include authorization for automatic withdrawal of any changed amount unless it is canceled as described herein. If Bank Account Holder calls the bank to stop payment, Bank Account Holder may be required to provide the bank with a written request within fourteen (14) days after the call. Bank Account Holder will be responsible for any service fee assessed by the bank for stop payment orders. Farm Bureau Health Plan or Wellmark may also charge Bank Account Holder a returned payment fee of $25 for any automatic withdrawal that is not honored by the bank.

I understand that automatic account withdrawal is a condition of enrolling in the Farm Bureau Health Plan. I understand that if I cancel my automatic payment and do not provide updated banking information or automatic withdrawal authorization, my coverage may be terminated. The Bank Account Holder may cancel automatic payment or provide updated banking information any time by notifying Wellmark in writing or by calling the number on the ID card by the 10th of the month prior to the next scheduled withdrawal in order to cancel automatic payment or provide new/updated banking information. If the request is not received by the 10th of the month prior to the next scheduled withdrawal, request may not be processed before the next withdrawal. The Bank Account Holder will be responsible for any fees assessed by the bank for insufficient funds or stop-payment orders made.

If at any time the member's account falls behind in payments, Farm Bureau Health Plan or Wellmark reserve the right to withdraw any amount necessary, including fees, to bring the account current with the next regularly scheduled automatic payment. In the event the Account Holder removes or fails to update banking information required for automatic withdrawal, or in the event the Account Holder does not make an electronic payment, I understand I will be switched to paper billing, and I may be subject to a paper biling processing fee in addition to the amount due for my plan. Farm Bureau Health Plan or Wellmark will not withdraw any amount above that which is due at the time of withdrawal; notice may not be provided to the bank account holder prior to said withdrawal. This authorization supersedes and replaces any previous authorization given by the Account Holder for automatic premium withdrawal.

Bank Account Holder's Name (as it appears on the account)_____

Authorized Signature of Bank Account Holder_____

Date of signature_____/_____/_____

Submit to: Wellmark Administrators, Inc.
PO Box 9232 Station 4W688
Des Moines, IA 50306-9232
OR
Fax: 515-376-9063

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