TRH HEALTH PLANS
CHOICE PLAN APPLICATION

PLEASE PRINT USING BLACK INK

Section 1	**Applicant Information**					**OFFICE USE ONLY**
First Name	MI	Last Name		Phone No. ( ) _____-_____ May we leave a message? ☐ Yes ☐ No		**Sub Group**
Mailing Address				Alternate No. ( ) _____-_____ May we leave a message? ☐ Yes ☐ No		**County**
City	State	Zip Code		Email Address (if applicable):		**Effective Date**
Date of Birth – –	Age	☐ Male ☐ Female	Marital Status (Optional) ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Date of Marriage/Divorce – –	Social Security No. – –	**ID Number**
Tobacco Use: ☐ Never ☐ Currently use tobacco products ☐ Previously used tobacco products but stopped on (DATE): _____			Height	Weight	Primary Care Physician:	**Action**
☐ Yes ☐ No Are you an existing TN Farm Bureau member? If "No", please submit a TN Farm Bureau Membership Application and Agreement. TN Farm Bureau membership is in the name of: _____ TN Farm Bureau membership number: _____			How did you hear about TRH? ☐ Internet ☐ TV ☐ Phone Book ☐ Radio ☐ Mail Ad ☐ Billboard ☐ TN Farm Bureau ☐ Family/Friend			

Section 2 — Application Type

☐ New Application for Coverage

☐ Reapplication - Current TRH subscriber re-applying for new coverage *(Under 65 Acknowledgement is required.)*. **Current ID Number: _____**

Section 3 — Coverage Options

The following coverage options are for adults over age 19 and contain at least a 6 month pre-existing condition waiting period.

☐ **Enhanced Choice - Deductible: ☐ $3000 ☐ $6000**
Individual Only

☐ **Direct Choice – $0 In-Network Deductible**
Individual Only

The following coverage options are for children age 19 or under and contain at least a 6 month pre-existing condition waiting period.

☐ **Enhanced Choice Child Coverage – Deductible: ☐ $3000 ☐ $6000**
Individual Only

☐ **Direct Choice Child Coverage – $0 In-Network Deductible**
Individual Only

Section 4 — Child Coverage Eligibility

Please answer the following questions if you are applying for child coverage:

☐ Yes ☐ No 1. Is the child for whom you are applying under the age of 19, and your (Please select all that apply):
☐ Biological child ☐ Adopted child ☐ Step-child
☐ Child placed with you in anticipation of adoption ☐ Child for whom you are legal guardian?
If "No," please explain _____

☐ Yes ☐ No 2. Are there documents establishing adoption, anticipation of adoption or guardianship for the child for whom you are applying?
If "Yes," please submit a complete copy of the final documents including but not limited to the Final Order of Adoption, documentation demonstrating the child has been placed with you in anticipation of adoption or a court order establishing guardianship.

TRH reserves the right to request proof of continuing eligibility at any time. In the event eligibility cannot be determined based on the answers submitted on the application, additional information may be requested.

Section 5 — General Information

Please Read Carefully as this Contains Important Information

Quoted premiums are only an estimate. This application will be medically underwritten. In addition to being medically underwritten, TRH coverages are age-rated. Rate adjustments will occur as you or the child for whom you are applying age. General rate adjustments may also be necessary. You will be notified by letter thirty (30) days in advance of any rate adjustment.

Maternity benefits will be available after coverage has been in effect for 6 consecutive months.

If you or the child for whom you are applying are currently an expectant mother or father, completion of a Newborn Waiver is required before the application can be processed. The Newborn Waiver establishes that the newborn child, upon delivery, will not have automatic coverage. A new application for the child will be required and the child will be medically underwritten. After the application process is complete, the newborn child may be granted the applicable coverage on the next available effective date.

THERE IS AT LEAST A 6-MONTH PRE-EXISTING CONDITION WAITING PERIOD FOR ANY CONDITIONS THAT WERE IN EXISTENCE PRIOR TO THIS COVERAGE'S EFFECTIVE DATE. A pre-existing condition is defined in the contract as: "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period applies regardless of any previous or current coverage (unless you are a dependent eligible to transfer from an existing TRH health plan). This is not an application designed to accommodate the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA); therefore, portable/creditable coverage does not apply and no portion of your applicable pre-existing condition waiting period will be waived. Any and all claims that are filed during this pre-existing condition waiting period will be reviewed by TRH to verify they are not related to a pre-existing condition.

Primary Applicant First Name	MI	Last

Section 6 Health Questionnaire

Please Read Carefully as this Contains Important Instructions for Completing the Health Questionnaire

All health questions must be answered "Yes" or "No". We are relying on the information you provide on this application to determine eligibility for coverage for you or the child for whom you are applying. Inaccurate or incomplete information provided on this application may constitute misrepresentation. Material misrepresentation could result in amended coverage or termination of coverage. Your full signature is required next to any changes you make to your responses to these questions.

You are encouraged to keep a personal copy of all medical records submitted to TRH. Once medical records are submitted to TRH, you must contact the TRH Privacy Office to obtain a copy of medical records. You will be charged a fee for the return of medical records.

When answering the questions in this application, consider the health of yourself or the child for whom you are applying. Claims experience from any previous TRH plan may be considered during the underwriting process.

Section 7 - A Health Questions

During the past ten (10) years, have you or the child for whom you are applying, received medical advice or treatment for; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

1.	Heart Attack, Heart Defects, Congestive Heart Failure or Heart Surgery?	☐ Yes ☐ No
2.	Cancer or Tumor(s)? (Not Skin Cancer) **If "Yes", Date of last treatment:**_____	☐ Yes ☐ No
3.	Stroke or Trans Ischemic Attack (TIA)?	☐ Yes ☐ No
4.	Kidney Disease, Kidney Failure or Renal Insufficiency?	☐ Yes ☐ No
5.	Diabetes?	☐ Yes ☐ No
6.	Lung Disease (such as Emphysema, Cystic Fibrosis or COPD)?	☐ Yes ☐ No
7.	Neurological Disorder (such as Brain Injury, Epilepsy, Cerebral Palsy, Multiple Sclerosis or Muscular Dystrophy)?	☐ Yes ☐ No
8.	Liver Disease (such as Cirrhosis of the Liver or Hepatitis C)?	☐ Yes ☐ No
9.	Auto Immune Disease (such as Rheumatoid Arthritis, AIDS or HIV)?	☐ Yes ☐ No
10.	Alcohol Abuse and/or Drug Use/Abuse **If "Yes", Date discontinued:**_____	☐ Yes ☐ No

Section 7 - B

1.	Do you or the child for whom you are applying have any pending test(s) or surgery(s)?	☐ Yes ☐ No
2.	Have you or the child for whom you are applying received all state recommended immunizations for the applicant's age group?	☐ Yes ☐ No
3.	Are you or the child for whom you are applying currently an expectant father or mother? If yes, completion of a Newborn Waiver is required.	☐ Yes ☐ No

Section 7 - C

List all medications that are currently being taken for you or the child for whom you are applying.

Name of Medication(s)	What illness or condition is this medication treating?	Is medication currently being taken?	Date Started	Date Stopped

Section 8 Acknowledgements and Agreements

Please Read Carefully and Initial Below

I understand and acknowledge:

- Any coverage which may be issued will contain a pre-existing condition waiting period of at least 6 months. ***(Please initial here:_____)***
- This is not an application designed to accommodate the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA); therefore, portable/creditable coverage does not apply and no portion of my applicable pre-existing condition waiting period will be waived. In applying for this coverage, I understand and acknowledge that other health insurance issuers make available to individuals other health coverage plans which do not require medical underwriting and do not contain pre-existing condition limitations for individuals who have met certain prior creditable coverage requirements. I hereby acknowledge that although such portable coverage may be available to me/us, based on rates or other reasons, I have declined to apply for such coverage at this time. ***(Please initial here:_____)***
- I must immediately notify TRH when there is any change in the information submitted on this application concerning eligibility for coverage. ***(Please initial here:_____)***

Primary Applicant First Name	MI	Last

IMPORTANT: The approval of this application is subject to medical underwriting guidelines. If you have current coverage, do not cancel your current coverage until you have been issued coverage by TRH and upon review, agree to accept the rate, terms and conditions of the contract.

If approved for coverage, you will be mailed a billing statement for the initial amount due. This billed amount will need to be paid by the due date. Once the billed amount has been paid, the automatic withdrawal from your bank account will begin on or after the 1st of the following month.

Your TRH Plan ID card(s) and contract should arrive within a few days of the billing. Please review both the identification card(s) and the contract carefully, as they contain important information. You will have 30 days from the date you receive your contract to decide if you want to continue the coverage.

Please Read Carefully and Sign the Appropriate Box Below

TRH is entitled to rely solely on the statements made on this application which are complete and correct.

I understand and acknowledge that any coverage which may be issued:

- Will be effective, subject to all the terms and conditions of the contract, on the date indicated with the issuance of the identification card;
- Shall be binding only if each statement included on the application is complete and true; and
- May be transferable to another coverage classification within the TRH program.

I authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm having any information necessary to determine the eligibility of the person for whom application is made, to give to TRH or its affiliates, all such information. I (or my personal representative) may request a copy of this authorization.

I understand the information in this application and any information obtained with this authorization will be used by TRH to determine eligibility for coverage and that coverage and rates will be affected by this information.

If I am not already a member, I hereby make application for membership in the Tennessee Farm Bureau/TRH. I understand this membership entitles me to apply for the services offered by TRH Health Plans and the Tennessee Farm Bureau.

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete for myself or the child for whom I am applying.

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

Acknowledgement for Adults Over Age 19

PLEASE COMPLETE THE FOLLOWING IF YOU ARE APPLYING FOR ENHANCED CHOICE OR DIRECT CHOICE.

Applicant Signature **Date**

Acknowledgement for Children 19 and Under

PLEASE COMPLETE THE FOLLOWING IF YOU ARE APPLYING FOR ENHANCED CHOICE CHILD COVERAGE OR DIRECT CHOICE CHILD COVERAGE.

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete for the child for whom I am applying. I understand that if coverage is issued, I am the only person allowed to sign for changes to or cancellation of this coverage.

Signature of Subscriber Parent, Step-Parent or Legal Guardian **Relationship** **Date**

Print Name of Subscriber Parent, Step-Parent or Legal Guardian **Social Security Number**

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete for the child for whom I am applying. I understand that if coverage is issued, I cannot sign for changes to or cancellation of this coverage. I understand as parent or legal guardian of the child, I may, depending upon the age of the child, have the right to obtain information about this child's application and coverage if issued.

Signature of Non-Subscriber Parent, Step-Parent or Legal Guardian **Relationship** **Date**

Print Name of Non-Subscriber Parent, Step-Parent or Legal Guardian

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

TRH Health Plans is a taxable, not-for-profit, membership organization which promotes health care for the rural people of Tennessee. Members can learn more about the programs and services offered by TRH Health Plans through their local Tennessee Farm Bureau office.

$6 Application Fee (Non-Refundable)

Checklist for Completing the TRH Choice Plan Application

- ☐ Complete SECTION 1 with current information for you or the child for whom you are applying.
- ☐ In SECTION 2, select the type of application.
- ☐ In SECTION 3, choose one (1) plan and one (1) deductible (if applicable).
- ☐ If applying for a child, complete SECTION 4 with current information and answer all questions regarding the child for whom you are applying.
- ☐ Read SECTION 5 and SECTION 6 carefully as they contain important information.
- ☐ In SECTION 7-A and SECTION 7-B, individually mark ALL QUESTIONS “YES” or “NO” for you or the child for whom you are applying.
- ☐ In SECTION 7-C, list all medications for you or the child for whom you are applying, as requested. If necessary, please add a separate sheet with additional information.
- ☐ In SECTION 8, read and initial each area as requested to acknowledge your understanding. If applying for yourself, complete the Acknowledgement for Adults Over Age 19 box. If applying for a child, complete the Acknowledgement for Children 19 and Under box.
- ☐ Please thoroughly review and sign your FULL NAME beside any changes or mistakes made on the application (even if white-out is used). Check the date that the application is signed. We cannot accept an application more than 30 days old.
- ☐ Complete the TRH Bank Draft Authorization (including payor information).
- ☐ Complete the Patient Protection and Affordable Care Act (“PPACA”) Acknowledgment.
- ☐ Complete the Farm Bureau Membership Application and Agreement form with EFT Agreement if you are not currently a member, and submit a $25 check made out to Tennessee Farm Bureau for your annual Farm Bureau membership dues.
- ☐ Include a $6 application processing fee (per application submitted) made out to TRH Health Plans.
- ☐ Return to TRH, P.O. Box 313, Columbia, TN 38402-0313, or deliver to your local Farm Bureau office. Go to trh.com to locate an office near you.

  - ◊ Completed TRH application
  - ◊ Completed Bank Draft Authorization
  - ◊ Completed PPACA Acknowledgement
  - ◊ $6 application fee
  - ◊ $25 membership fee and Farm Bureau Membership Application form with EFT Agreement (if applicable)

TRH's Toll-free number is 1-877-874-8323, 7:00 a.m. - 5:00 p.m., CST

Don't forget! Your Farm Bureau membership means you have access to an array of services -- including automobile, homeowners and life insurance products, discounts for security systems, cellular phone service and hotels.

TRH HEALTH PLANS
Live better. Save more. Farm Bureau

INSTRUCTIONS FOR BANK DRAFT AUTHORIZATION

The following must be completed to authorize your automatic bank draft after you pay the initial paper invoice. If you are changing bank account information, this form must be received in our office ten (10) days prior to the next scheduled draft date.

1. ***Signature of Applicant/Subscriber*** (Required) – Subscriber must sign and date that he/she agrees to the terms and conditions as set forth in the Bank Draft Authorization. The Bank Draft Authorization must be signed by parent or legal guardian if member is under age 19.

2. ***Signature of Payor*** (Required) and ***Print Payor Name*** (Required) – Payor (owner/signatory of account) must sign and print name.

3. ***Applicant/Subscriber Name*** (Print) – Subscriber must print name.

4. ***Identification Number*** – Subscriber's TRH identification number must be included.

5. Check ***"Health," "Dental,"*** and/or ***"Prescription"*** box(es) that apply.

6. Check ***"Bank Change"*** box and write in effective date of change.

7. Check **Account Type – "Checking" or "Savings".**

8. Attach voided check to bottom of form if bank account is checking. ***Deposit slips will not be accepted.*** If savings account, this form must be taken to your financial institution for completion, including signature and telephone number of authorized representative.

9. Mail completed form to ***TRH Health Plans, P.O. Box 313, Columbia, TN 38402-0313, or you may fax to (931) 560-4278, Attention: Billing Department***.

10. Verify receipt of mailed or faxed form by calling (931) 388-7872 or toll free (877) 874-8323 and request to speak to a Billing Department representative.

Please note: Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.

TRH HEALTH PLANS
Live better. Save more. Farm Bureau

BANK DRAFT AUTHORIZATION

☐ **Health** ☐ **Dental** ☐ **Prescription** **(Check all that apply)**

I hereby authorize TRH Health Plans ("TRH") to initiate debit entries from the account indicated below for the monthly payment of health, dental, or prescription coverage. The depository named below 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 further understand I have the right to revoke this authorization by notifying TRH in writing at least ten (10) days prior to the time payment is due. I further agree that should a debit be dishonored, whether with or without cause and whether intentionally or inadvertently, TRH shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

_____ _____
Print Applicant/Subscriber Name (Required) **Print Payor Name (Required)**

_____ _____
Signature of Applicant/Subscriber (Required) **Signature of Payor (Required)**
(Must be signed by parent, step-parent or legal guardian of minor applicant)

_____ _____ _____
Date **County** **Subgroup**

_____ _____ _____
TRH ID Number-Health **TRH ID Number-Dental** **TRH ID Number-Prescription**

☐ Quarterly to Bank Draft _____ ☐ **ACCOUNT TYPE -** ☐ Checking ☐ Savings
☐ New Application (effective date)
☐ Transfer
☐ Bank Change _____
(effective date)

PLEASE READ CAREFULLY

For Checking Accounts: Attach voided check here (No Deposit Slips)
For Savings Accounts: Take form to Financial Institution for completion (No Deposit Slips)

_____
Name and Address of Financial Institution

_____ _____
Routing Number **Account Number**

_____ _____
Signature, Authorized Representative of Financial Institution **Telephone Number**

Cancellation- The Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to TRH. Coverage will remain in effect until the paid-to date. Please see your contract for specific information regarding cancellations and cancellations due to death of Subscriber.

Patient Protection and Affordable Care Act Acknowledgment

I hereby acknowledge my understanding of the following:

1. The health benefits coverage for which I am applying through TRH Health Plans is not covered by the federal Patient Protection and Affordable Care Act ("PPACA") and does not meet the current PPACA requirements for individual health insurance.

2. Under PPACA, individuals are required to purchase minimum essential coverage. Since the TRH Health Plans coverage for which I am applying is not covered by PPACA, and does not meet the PPACA requirements for individual health insurance, it is not considered minimum essential coverage.

3. Because this TRH coverage is not considered minimum essential coverage, I will be subject to a tax under the individual shared responsibility provision of PPACA.

_____ _____

Applicant Signature **Date**