Kansas Farm Bureau® Health Plans

Kansas Farm Bureau Health Plans
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KFBHP COVERAGE CANCELLATION FORM

Subscriber Name	Subscriber's Date of Birth
Health Plan ID	Dental Plan ID

☐ **Cancel my coverage.** **(Please see "Coverage Termination" section below.)**

Reason: ☐**Obtained Employer Coverage** ☐**Other Individual Coverage** ☐**Affordability**

Effective Date of Cancellation: _____/_____/_____

Subscriber Signature: X _____ **Date:** _____

☐ **Cancel coverage due to death.** **Subscriber Deceased on:** _____/_____/_____

(Please provide us with the name and address of the Executor of the Estate.)

Executor's Name: _____ **Daytime Phone No:**_____

Mailing Address:_____

City:_____ **State:** _____ **Zip Code:** _____

Executor's 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.

Coverage Termination

You, as a Subscriber, can cancel the Coverage for any reason by giving 10 days written notice to Kansas Farm Bureau Health Plans. Your coverage will terminate the following paid-to date. ***Please note - once a cancellation is processed it cannot be revoked. In order to obtain new coverage, medical underwriting for approval and pre-existing condition waiting periods will apply.***

If Coverage terminates as a result of Your death and there are no dependents covered, Coverage ends on the date of death and Your estate is entitled to a refund of any unused premiums.

If You are on a monthly bank draft, You have the option to stop payment at Your bank, provided You present Your bank with the proper account information and exact bank draft amount.