PFB HEALTH SERVICES VISION COVERAGE

2024 Monthly Group Rates, Important Guidelines, and Application

SECTION A: GENERAL INFORMATION

Please enroll me in: ☐ Standard Plan ☐ Enhanced Plan

All Areas (Statewide Rates)	Standard Vision	Enhanced Vision
Single	$ 6.89	$ 8.92
Husband & Wife	$ 13.74	$ 17.84
Parent & Child	$ 11.02	$ 14.29
Parent & Children	$ 13.09	$ 16.94
Family	$ 20.66	$ 26.75

Important Guidelines

1. This program is a Pennsylvania Farm Bureau members' benefit. You must be a member of the Farm Bureau to participate in this group coverage.
2. Coverage becomes effective the first of the month following receipt of the application unless otherwise specified by contract holder or Pennsylvania Farm Bureau.
3. You must keep this coverage in effect for a minimum of two years. By signing the application, you agree to the terms of the contract.

SECTION B: APPLICANT INFORMATION – Please Print Clearly

My PFB Membership Number is	New PFB Member, Check here: ☐	Social Security Number	Group Number (leave blank)	Effective Date

Name Last	First	Middle Initial	Phone Number

Home Address	City	State	Zip

Birth Date Month/Day/Year	Marital Status	Sex	Employer
	☐ Married ☐ Single	☐ Male ☐ Female	

Please check one ☐ Farmer ☐ Part-Time Farmers ☐ Non-Farmer ☐ Agri-Business

SECTION C: DEPENDENT INFORMATION
Include Spouse and Unmarried Children (print first name and middle initial)

Unmarried dependent children covered to age 23.

Name	Social Security Number	Date of Birth	
☐ Spouse			
☐ Son ☐ Daughter	Social Security Number	Date of Birth	
☐ Son ☐ Daughter	Social Security Number	Date of Birth	
☐ Son ☐ Daughter	Social Security Number	Date of Birth	
☐ Son ☐ Daughter	Social Security Number	Date of Birth	
☐ Son ☐ Daughter	Social Security Number	Date of Birth	
☐ Son ☐ Daughter	Social Security Number	Date of Birth	

I hereby apply for the coverage indicated. I understand this application is subject to approval by the plans, and any coverage provided will be subject to the terms of the agreement. If applying for group enrollment, I am eligible for the benefit program in effect at my place of employment. Any person or organization having provided or who may provide health care services to me or any persons named on this application either prior to or during the period of this contract is authorized to furnish to the plans any information or records relating to these services. I verify that the information supplied by me is correct to the best of my knowledge and belief.

Signature

Spouse's Signature

Date

Current Subscriber of PFB's Health Insurance Coverage ☐ **Yes** ☐ **No**

Pennsylvania Farm Bureau Health Services

Return this application along with your first monthly premium.
Check should be made payable to: *PFB Members' Service Corp.*

Any questions, please call us at 1-800-522-2375

Mail to:
PFB Health Services
P O Box 8736
Camp Hill, PA 17001-8736