Indiana Farm Bureau®
Health Plans

Request for Reconsideration of Rate

Member Name:_____ ID Number: _____

I wish to submit the following request for the Indiana Farm Bureau Health Plans Underwriting Department to reconsider my rate for coverage.

What you need to know:

- When processing a Reconsideration of Rate, the Indiana Farm Bureau Health Plans Underwriting Department will review all current health conditions, medications, and/or treatment to determine if you are eligible for a rate reduction based on our current underwriting standards. If the factors in your original underwriting decision are resolved in your favor, it may be possible that current health conditions, medications, and/or treatment will prevent a rate reduction to be allowed for rate on your coverage at this time.
- Claims experience may be used in the reconsideration process.
- This information submitted may result in the Indiana Farm Bureau Health Plans Underwriting Department requesting additional medical information.
- If you and/or your spouse are age 40 or older, we may need current medical records including height, weight and blood pressure readings (within the last 12 months), fasting lipid (cholesterol) panel, fasting glucose (sugar) results, and a list of current medications (within the last 12 months).
- If current medical conditions or treatments do not allow a reduction in your current rate for coverage, there may be a Lower Premium Option for Coverage available.

List all medications that are currently being taken or have been taken in the last two (2) years for you, your spouse, and all dependent children on this contract (if additional space is needed for dependents, please attach a separate page):

Name:	Name of Drug:	Illness:	Date Started:	Date Stopped:

List a current height and weight for everyone on this contract:

Name:	Height:	Weight:	Date Weighed:

You may also attach pertinent documents including medical records, pharmacy records, and any other information you would like considered during the reconsideration process.

Please send this form along with any documentation to:
Email: underwritingforms@fbhealthservices.com | Fax: 931-560-4304

I understand the information in this request for reconsideration and any information obtained with this authorization will be used by Indiana Farm Bureau Health Plans to determine the outcome of this reconsideration. I declare that the foregoing statements provided by me on this request in its entirety are true, correct and complete for myself, my spouse and all dependent children.

Member Signature:_____ Spouse Signature:_____ Date: _____