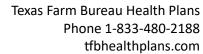


Request for Reconsideration of Rate

Member Name:		ID Num	ber:		
I wish to submit the following request to Texas Farm Bureau Health Plans Enrollment Department to reconsider my rate for coverage.					
What you need to	know:				
 When processing a Reconsideration of Rate, Texas Farm Bureau Health Plans Enrollment Department will review <u>all</u> 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, medication, and/or treatment will prevent a rate reduction to be allowed for your coverage at this time. Claims experience from any previous Texas Farm Bureau Health Plan coverage will be used in the reconsideration process. Any information submitted may result in the Texas Farm Bureau Health Plans Enrollment Department requesting additional medical information. If you and/or your dependents were originally rated for height and weight, blood pressure reading, blood pressure medication, cholesterol reading or cholesterol medication, glucose reading or Hemoglobin A1C Reading, we will require current readings in the last 12 months taken by a healthcare professional to review your rate. If your plan is a family plan, we will require the form be completed with everyone's information listed on the contract to reconsider your family rate. If not completed in entirety, we will have to return the form. 					
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:					
Name:	Name of Drug:	Illness:	Date Started:	Date Stopped:	

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List current height and weight for you, your spouse, and all dependent children on this contract.

contract.			
Name:	Height:	Weight:	Date Weighed:
-	endents on plan had any the last 7 years?	disease, disorder, med	ical condition, symptom, or
			·
•	ch pertinent documents in you would like considere	•	ds, pharmacy records, and any eration process.
Please send this f	orm along with any docu	mentation to the below	ı address:
		m Bureau Health Plans	
	Attention:	Enrollment Department PO Box 313	
		bia, TN 38402-0313	
		ngforms@fbhpservices :: 931-560-4304	<u>com</u>
with this authoriz outcome of this r	ration will be used by Texa econsideration. I declare	as Farm Bureau Health I the foregoing statemen	and any information obtained Plans to determine the nts provided by me in this my spouse, and all dependent
Member Signatu	re:		
Spouse Signature	:		

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