Kansas Farm Bureau Health Plans
Phone 1-833-282-5928
kfbhealthplans.com

Request for Reconsideration of Rate

Member Name: _____ ID Number: _____

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

What you need to know:

- When processing a Reconsideration of Rate, Kansas Farm Bureau Health Plans Enrollment 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, medication, and/or treatment will prevent a rate reduction to be allowed for your coverage at this time.
- Claims experience from any previous Kansas Farm Bureau Health Plan coverage will be used in the reconsideration process.
- Any information submitted may result in the Kansas 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.

Name:	Height:	Weight:	Date Weighed:

Have you or dependents on plan had any disease, disorder, medical condition, symptom, or treatment within the last 7 years?

_____

_____

_____.

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 the below address:

Kansas Farm Bureau Health Plans
Attention: Enrollment Department
PO Box 313
Columbia, TN 38402-0313
Email: underwritingforms@fbhpservices.com
Fax: 931-560-4293

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

Member Signature: _____

Spouse Signature: _____

Date: _____