Kansas Farm Bureau® Health Plans

Request for Reconsideration of Rider

Member Name:_____ **ID Number:**_____

I wish to submit the following request for the Kansas Farm Bureau Health Plans Underwriting Department to reconsider a Benefit Exclusion Rider (hereto referred to as "Rider"). Claims experience may be used in the reconsideration process.

Name of Person with Rider:
Description of Rider:

Answer each of the following questions completely and accurately. **We will not be able to process this request without the requested information.**

1. In the last two (2) years, has the person with the Rider had symptoms, pain, or received treatment related to the condition excluded by the Rider? Circle: YES or NO. If "YES," please explain in detail: _____

2. When was the last date the person with the Rider had symptoms, pain, or received treatment related to the condition excluded by the Rider? Please be specific (month, year). _____

3. List all medications that the person with the Benefit Exclusion Rider is currently taking or has been advised to take in the last two (2) years for the condition excluded by the Benefit Exclusion Rider:

Name of Drug	Is medication currently being taken?	Date Started	Date Stopped

Use the space below to provide any additional information for reconsideration.

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@fbhpservices.com | Fax: 1-931-560-4293

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 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: _____