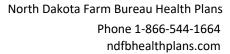


## Request for Reconsideration of Rate

Member Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

	ne following request consider my rate fo		arm Bureau Health	Plans Enrollment
What you need to	know:			
Enrollment I to determine standards. If be possible t reduction to Claims exper used in the r Any informa Enrollment I If you and/or reading, blood reading or H taken by a he If your plan i listed on the to return the	e if you are eligible for the factors in your or that current health combe allowed for your or election submitted may rependents we allowed pressure medication and pressure medication at the professional seafamily plan, we will contract to reconsideration and contract to reconsiderations.	w all current health or a rate reduction barriginal underwriting or onditions, medication coverage at this time ous North Dakota Faress.  The essent in the North Dakes additional medical ere originally rated for on, cholesterol reading, we will require cuil to review your rate. If the require the form beer your family rate. If the being taken or have	onditions, medications and on our current undecision are resolved, and/or treatment words.  It makes a Bureau Health Plack of the Farm Bureau Health Plack of the Information.  It height and weight, and or cholesterol mediurrent readings in the Eurrent readings in the Eurrent completed with every not completed in enterior of the Europe E	ns, and/or treatment nderwriting in your favor, it may will prevent a rate n coverage will be talth Plans blood pressure dication, glucose e last 12 months eryone's information tirety, we will have
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.

	Height:	Weight:	Date Weighed:
Have you or dependent treatment within the	-	disease, disorder, med	ical condition, symptom, or
You may also attach	pertinent documents	including medical recor	ds, pharmacy records, and any
other information yo	u would like consider	ed during the reconside	ration process.
Please ser	nd this form along with	:h any documentation to	a the helew address:
Flease sei	_	•	
	North Dakota	a Farm Bureau Health Plar	ns
	Attention:	Enrollment Department	
		Enrollment Department PO Box 313	
	Colum	Enrollment Department	
	Colum Email: <u>underwrit</u>	Enrollment Department PO Box 313 Ibia, TN 38402-0313	
with this authorization the outcome of this i	Colum Email: <u>underwrit</u> Fa ormation in this Requ on will be used by No reconsideration. I dec	Enrollment Department PO Box 313 bia, TN 38402-0313 ingforms@fbhpservices x: 931-560-4304 est for Reconsideration rth Dakota Farm Bureau clare the foregoing state	s.com
with this authorization the outcome of this request in its entirety children.	Colum Email: <u>underwrit</u> Fa ormation in this Requ on will be used by No reconsideration. I dec y are true, correct, an	Enrollment Department PO Box 313 bia, TN 38402-0313 ingforms@fbhpservices x: 931-560-4304 est for Reconsideration rth Dakota Farm Bureau clare the foregoing state d complete for myself, r	and any information obtained u Health Plans to determine ements provided by me in this
with this authorization the outcome of this request in its entirety	Colum Email: <u>underwrit</u> Fa ormation in this Requ on will be used by No reconsideration. I ded y are true, correct, an	Enrollment Department PO Box 313 bia, TN 38402-0313 ingforms@fbhpservices x: 931-560-4304 est for Reconsideration rth Dakota Farm Bureau clare the foregoing state d complete for myself, r	and any information obtained Health Plans to determine ements provided by me in this

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