

Attention Provider: Any expense incurred in obtaining medical records is to be paid by the **patient**.

Date: _____
Primary Applicant Name: _____
Address: _____
City, ST, Zip: _____

Patient Name: _____
DOB: _____
County Office: _____

The following medical information is a requirement for adults **ages 40 thru 64**, who are applying for coverage with Farm Bureau Health Plans and can be submitted along with submitting health coverage application.

This information submitted may result in the Farm Bureau Health Plans Medical Underwriting department requesting further medical information to adequately underwrite your application. Prompt return of all information requested below is necessary to complete the underwriting process.

Please return a copy of this form and any requested medical information to KFBHP to keep your application for health coverage from expiring. Deadline for submission: _____

Medical information needed for: Date of birth:

Please submit medical information regarding:

1. **Current height, weight, and blood pressure readings taken within the last 12 months.**
2. **Fasting lipid (cholesterol) panel results taken within the last 12 months.**
3. **Fasting glucose (sugar) results taken within the last 12 months.**
4. **List of current medications and conditions for which medications prescribed.**

All of the above information is required for the purpose of underwriting your application.

Please submit this form and medical records to KFBHP. See the attached HIPAA Authorization Form.

Email: underwritingforms@kfbhp.com | **Fax:** 931-560-4293

Applicant is encouraged to keep a personal copy of all medical records submitted to KFBHP. To obtain a copy of medical records from KFBHP, the applicant must contact the KFBHP Privacy Office. There will be a charge for the return of medical records.



HIPAA Authorization

Plan Type _____
Applicant Name _____
SSN _____ DOB _____
Address _____
City _____ State _____ Zip _____

I hereby authorize the use or disclosure of protected health information ("PHI") about me as described below:

1. I authorize Kansas Farm Bureau Health Plans ("KFBHP") to use **the PHI I have provided on the application form to determine my initial and continued eligibility to obtain coverage under the health and/or dental coverage for which I have applied, to determine the rates and terms which apply to the plan.**
2. The following group of persons employed or working for KFBHP may use or disclose my PHI, which is described above: **Employees involved in accounting, review of medical records and membership services processes.**
3. The information which is disclosed by KFBHP shall be disclosed only to _____, and solely for the limited purposes identified in this authorization.
4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by KFBHP in reliance on this authorization, by sending a written revocation to: **KFBHP, Attn: Privacy Office, P.O. Box 1424, Columbia, TN 38402-1424; Fax: 931-388-8326.**
5. This authorization will expire one hundred eighty (180) days *after* I have dis-enrolled from or become ineligible to participate in this health and/or dental coverage.
6. I understand that the information which will be provided under this authorization is necessary for KFBHP to fulfill its obligation to provide health and/or dental coverage to members of KFBHP and that KFBHP will condition enrollment and eligibility in the health and/or dental benefits plan/policy on my providing this authorization, and my application may be denied and/or eligibility revoked, if I refuse to provide this authorization or revoke this authorization.
7. I understand that if the person or entity that receives my PHI is not a health care provider or a health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulation. ***I have been advised, however, that KFBHP and The Kansas Farm Bureau have entered into a confidentiality agreement with regard to any PHI used or disclosed by KFBHP to The Kansas Farm Bureau for the purpose defined above.***

Applicant Name (or Legal Representative)

Signature

Date