SOUTH DAKOTA FARM BUREAU®
Health Plans
MEDICARE SUPPLEMENT PLANS
Insured By Members Health Insurance Company

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REQUEST FOR RECONSIDERATION OF TOBACCO RATE

General Information

Please send this form along with any documentation to the address listed in the upper right hand corner.

Subscriber Information

First Name	MI	Last Name

Health Plan Subscriber ID Number

Tobacco Use Information

- Answer each of the following questions completely and accurately for you.
- **This request will not be processed without the requested information.**

☐ Yes ☐ No Have you used tobacco in any form (i.e. cigarettes, cigars, pipe, chewing tobacco or snuff) in the past five (5) years? If Yes, Last Date of Tobacco Use: _____

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

Authorization

I understand the information in this request for reconsideration and any information obtained with this authorization will be used by South Dakota Farm Bureau Health Plans to determine the outcome of the reconsideration. I declare that the foregoing statements provided by me on this request in its entirety are true, correct and complete for myself.

Subscriber Signature **Today's Date**

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

MH-SD-BL-FL21-107