NEBRASKA

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Request for Premium Rate Reduction Due to Change in Health Status or Tobacco Cessation Medical Questionnaire

Please complete and submit this form to Blue Cross Blue Shield of Nebraska (BCBSNE), Individual Underwriting Department, P.O. Box 2417, Omaha, NE 68103-2417 or by secure fax to (402) 548-4685 with any additional medical information specific to any ongoing conditions or treatments you have received and want reviewed for possible premium reduction. You may be requested to provide additional information in order for BCBSNE to complete your review.

BCBSNE will review your health history, including current tobacco status, to determine if your premium rate can be reduced. If you qualify to have your premium rate reduced, it will be in effect the first of the month following approval. Submitting this request does not guarantee a premium rate reduction. Premium rates are subject to relative health status and underwriting approval.

Please answer each question.

1. Within the past 12 months, have you used tobacco products, including cigarettes, cigars, pipe or chewing tobacco? ☐ Yes ☐ No

2. Within the past ten years, have you had treatment for, a diagnosis of, or any injury related to, or testing or advice related to the following *(you should not disclose genetic information including family history):*

   a. Abnormal test results (for example: PSA, liver enzymes, other lab testing or x-rays) ☐ Yes ☐ No

      If yes, please explain: _____

      _____

   b. Consultation, exam, treatment, hospitalization or medical testing - or have been advised of the need for any future treatment or surgery or is currently ill or having symptoms of ill health ☐ Yes ☐ No

      If yes, please explain: _____

      _____

I hereby authorize BCBSNE to review my health history, including personal health information (PHI), to determine if I qualify to have my premium rate reduced. I understand that PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcriber hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. I understand that PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug abuse).

I represent that my answers in this questionnaire are true and correct to the best of my knowledge and belief and acknowledge that BCBSNE has relied on these answers in determining whether or not I qualify for a premium rate reduction.

_____ SIGNATURE

_____ DATE

(Signature of parent or legal guardian is required if member is under the age of 19)

_____ PRINTED NAME

_____ ID NUMBER

89-077 (09-20-11)

For MUW Only: ☐ APPROVED ☐ REJECTED Effective Date: