Appeal Application

You may upload this form to BeniComp.com/appeals

Fax or Mail Appeals to:
BeniComp, Inc.
ATTN: Appeals Department
8310 Clinton Park Drive
Fort Wayne , IN 46825
Fax: (219) 755-6033

Participant Information	Please **PRINT** all Information		
First Name	Last Name		
Street Address, Apt #, PO Box			
City		State	Zip Code
Home Phone (with area code)	Daytime or Cell Phone (with area code)	Email Address	
Employer Name	Social Security Number or Medical ID Number		

Appeal Request	
Please Note:	• **Any appeal and ALL supporting documentation *must be received* by BeniComp within thirty (30) days from the date the test results were mailed to the individual.** • The appeal will be evaluated by the Plan Administrator and include consultation with a medical advisor as needed. This decision rendered will apply to the applicable plan year. • Any re-testing and/or medical documentation supplied will generally be at the expense of the employee. If a wellness benefit is available through the current health plan and has not been exhausted, the re-testing cost may be covered by it. Please verify coverage with your Base Medical Plan Administrator. • **QUESTIONS? Contact BeniComp Customer Service Toll Free at (866) 797-3343.**

Which Category / Result(s) do you wish to appeal?

Check the category that you wish to appeal,
and then list the company goal and your results for that goal as shown on your BCA Lab Results Report.

	Goal	*Your Result*
BMI	_____	_____
BP	_____	_____
LDL	_____	_____
Tobacco / Nicotine	_____	_____
Other: _____	_____	_____

Why are you appealing?

Please provide a physician's statement and any supporting documentation for sections A and B.

I believe the test results to be inaccurate. Appealing for full credit. **(Complete Section A.)**

It is unreasonably difficult due to a medical condition or medically inadvisable for me to attempt to achieve these goals. Appealing for full credit. **(Complete Section B including the physician's statement.)**

Appeal Application

Section A *Check Area(s) being Appealed:*	**List of Acceptable Appeal Documentation** *Documentation including an authorized physician's statement or medical lab report must be attached for appeal to be processed.*	
Inaccurate Test Results Appealing for Full Credit	Body Mass Index ☐	Re-tested by qualified medical personnel including waist and hip circumference measurements. Height and weight must be measured without shoes.
	Blood Pressure ☐	An individual may either 1) be re-tested by their physician or 2) provide four readings taken within the past six (6) months from their physician.
	Cholesterol ☐	Re-tested by a certified laboratory.
	Tobacco Use ☐	A disputed positive lab result may be re-tested by a certified laboratory. Blood or urine-based nicotine tests will be accepted.
	Glucose ☐	Re-tested by a certified laboratory. Must be a 12-hour fasting specimen.
	Other ☐	_____

Section B – Appealing for Full Credit	**Medical Exception** *If it is unreasonably difficult due to a medical condition for an individual to achieve the standards for rewards under the program or if it is medically inadvisable for an individual to attempt to achieve the standards under this program additional Benicomp approved options are available to earn rewards.*

Please explain why you believe that attempting to achieve the goals under this program would be unreasonably difficult or medically inadvisable:

If an alternative is made available, I prefer: (choose one)

☐ Internet-Based, Self-Paced Programs ☐ Hard-Copy / Paper-Based Programs

If available, would you be interested in working with a personal health coach (telephonic)? ☐ Yes ☐ No

Section B continued **Physician's Statement**	*I have reviewed this participant's biometric screening results and agree that attempting to achieve the goals indicated would be unreasonably difficult due to a medical condition or medically inadvisable for them to attempt.*

Explain (attach available supporting documentation):

What alternative goals do you believe would be reasonable and advisable within the next 90 days (amount of weight loss, cholesterol/blood pressure reduction goals, etc.)?

Date:	***Phone number:***
Physician's Signature:	***Tax ID:***

Participant's Signature	*By signing, I verify that the information supplied by myself or my representative here is true and complete. I also understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files, a statement of claim, or an application containing any false, incomplete, or misleading information will be subject to criminal penalties applicable to state laws.*

Signature of Participant:	***Date:***
Printed Name:	

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BCA USE ONLY – Do not write below this line					
☐ Approved	☐ Denied	Code (if Applicable):	Reviewer's Initials:	Date:	Note:
Date Participant Contacted:		Option Chosen:	Completion Date:		

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The BeniComp supplemental program is underwritten by:
Assurity Life Insurance Co., Lincoln, NE
or Pan-American Life Insurance Co., New Orleans, LA