



Appeal Application
Fax or Mail Appeals to:

BeniComp Advantage, Inc
 ATTN: Appeals Department
 8310 Clinton Park Drive
 Fort Wayne, IN 46825
Fax: 260-482-8991
Toll Free: 866-222-0102

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:	<ul style="list-style-type: none"> • Any appeal and ALL supporting documentation <i>must be received</i> 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 866-222-0102.

Which Category / Result(s) do you wish to appeal?		
<p align="center"><i>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.</i></p>		
	<u>Goal</u>	<u>Your Result</u>
<input type="checkbox"/> BMI	_____	_____
<input type="checkbox"/> BP	_____	_____
<input type="checkbox"/> LDL	_____	_____
<input type="checkbox"/> Tobacco / Nicotine	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

Why are you appealing?	
<p align="center"><i>Please provide a physician's statement and any supporting documentation for sections A and B.</i></p>	
<input type="checkbox"/>	I believe the test results to be inaccurate. Appealing for full credit. (Complete Section A.)
<input type="checkbox"/>	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 <i>Check Area(s) being Appealed:</i>	List of Acceptable Appeal Documentation <i>Documentation including an authorized physician's statement or medical lab report must be attached for appeal to be processed.</i>	
Inaccurate Test Results Appealing for Full Credit	Body Mass Index <input type="checkbox"/>	Re-tested by qualified medical personnel including waist and hip circumference measurements. Height and weight must be measured without shoes.
	Blood Pressure <input type="checkbox"/>	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 <input type="checkbox"/>	Re-tested by a certified laboratory.
	Tobacco Use <input type="checkbox"/>	A disputed positive lab result may be re-tested by a certified laboratory. Blood or urine-based nicotine tests will be accepted.
	Glucose <input type="checkbox"/>	Re-tested by a certified laboratory. Must be a 12-hour fasting specimen.
	Other <input type="checkbox"/>	_____

Section B – Appealing for Full Credit	Medical Exception <i>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 Advantage approved options are available to earn rewards.</i>
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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

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Section B continued Physician's Statement	<i>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.</i>
<p>Explain (attach available supporting documentation):</p> <p>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.)?</p>	
Date:	Phone number:
Physician's Signature:	Tax ID:

Participant's Signature	<i>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.</i>
Signature of Participant:	Date:
Printed Name:	

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BCA USE ONLY – Do not write below this line					
<input type="checkbox"/>	<input type="checkbox"/>	Code (if Applicable):	Reviewer's Initials:	Date:	Note:
Approved	Denied				
Date Participant Contacted:		Option Chosen:	Completion Date:		

QUESTIONS? Contact BeniComp Advantage Customer Service Toll Free at 866-222-0102.

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