

DECISION REVIEW FORM

This form may be used to request the review of a decision or file a complaint.

| | |
|--|---|
| Applicant/Insured Name | |
| Is this a change? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Mailing Address | |
| Telephone Number | |
| Facsimile Number | |
| E-Mail Address | |
| Certificate/Policy Number | |
| Company Name | |
| What decision are you requesting to be reviewed? | <input type="checkbox"/> Underwriting <input type="checkbox"/> Refund <input type="checkbox"/> Claims <input type="checkbox"/> (Other) |

Please provide details below regarding your request. (Attach additional sheets if needed.)

| |
|--|
| |
|--|

Please attach all documentation you believe will assist in the review of your request including: medical records, letters from physicians, brochures, notes, receipts, etc.

| | | | | |
|----------------------------------|---------------------------------|-------------------------------|------------------------------|------------------------------------|
| How do you want to be contacted? | <input type="checkbox"/> E-Mail | <input type="checkbox"/> Mail | <input type="checkbox"/> Fax | <input type="checkbox"/> Telephone |
|----------------------------------|---------------------------------|-------------------------------|------------------------------|------------------------------------|

Applicant/Insured Signature _____ Date _____

Please Remit This Form To:
Kristi Colbert, Manager
Consumer Affairs Department
P.O. BOX 982010
North Richland Hills, TX 76182-8010
Telephone: 800-889-8223
Fax: 817-255-3585
Email: consumeraffairs@HealthMarkets.com