Claim Appeal Form

Purpose

This form is used if you disagree, in whole or in part, with our decision regarding your claim for benefits and are appealing our decision.

Instructions

1. **Complete** and sign this form.
2. **Submit** the original form to your third-party administrator and keep a copy for yourself.

SECTION 1
Participant

First Name _____ Middle Initial _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Email Address _____

Last 3 of SSN or Account Number _____ Employer _____

SECTION 2
Claim Information

Please provide the claim number and the reason for your appeal. If you have additional information that was not submitted in the initial claim, please provide it with this appeal.

Claim Submission Date _____ Type of Account _____ Claim ID _____

A brief description of your reason for appealing:

SECTION 3
Signature

Authorized Signature* _____ Date (mm/dd/yyyy) _____

*If a person other than the participant claimant is filing this appeal, please provide documentation of authorization.

SECTION 4

General Guidelines

You must file your request for review within the allocated time after the date you receive your notice of claim denial. **For benefits without deadlines listed, please consult your plan documents.** Failure to file a timely appeal will bar you from any further review of this benefit denial under these procedures.

Benefit Account	Deadline to Appeal
FSA	180 days after you received notice of denial
HRA	180 days after you received notice of denial
ICHRA	180 days after you received notice of denial
LPFSA	180 days after you received notice of denial

Once you submit this form to appeal our decision, you will receive a full and fair review of this adverse benefit determination, and the review will be conducted by someone who was not involved in the initial claim denial and who is not a subordinate of anyone who decided the initial claim denial. You will be notified of the decision on your request for review within a reasonable period of time after the date your appeal is received.

If you do not agree with the final determination on review and your claim relates to a plan subject to ERISA, you have the right to bring a civil action under Section 502(a) of ERISA. Review your benefit summary for a description of any appeal rights and procedures.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: Employee Benefits Security Administration at 1-866-444-EBSA (3272).