

Appeal Request Form - Active Employee - 2018 Enrollment

Purpose of Form: An appeal is a request from an employee and/or agency for an eligibility exception due to an error in enrollment or an extenuating circumstance.

Step 1:

Employee: Complete this form and give it to your agency's benefit liaison.

Benefit Liaison: Review the appeal and add any relevant comments.

Step 2:

Benefit Liaison: Submit this form along with supporting documentation and a copy of a completed 2018 Active Enrollment Form to:

Email: benefitsissues@azdoa.gov, Subject: "2018 Appeal, Last Name, EIN" Example: "2018 Appeal, Smith, 000001" | **Fax:** 602-542-4744

Mail: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 260, Phoenix, AZ 85007 ATTN: Member Services - Appeals

Please check the selection(s) that best describes your appeal:

- | | |
|---|---|
| <input type="checkbox"/> Request for change submitted more than 31 days after eligible date | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Error with online enrollment. Provide confirmation. | <input type="checkbox"/> Birth/Adoption |
| <input type="checkbox"/> Extenuating circumstances in which elections must be changed | <input type="checkbox"/> Divorce/Legal Separation |
| <input type="checkbox"/> Change in work schedule | <input type="checkbox"/> Gain or Loss of other coverage |
| <input type="checkbox"/> Did not enroll during New Hire Enrollment period | <input type="checkbox"/> Death of spouse/dependent |
| <input type="checkbox"/> Moved out of area | <input type="checkbox"/> Flexible spending account enrollment error |

Is this a second appeal? Yes No *If yes, an appeal is a request to a change previous adverse decision made by ADOA-Benefit Services. You and/or agency may appeal the adverse decision related to your coverage.*

Name (Last)	(First)	(MI)	Employee EIN	Last 4 digits of Social Security Number
Street Address		City, State, Zip Code		Agency
Email Address		Phone Number		Phone Number (alternate)

Please provide an explanation of your situation that requires an appeal and the action you are requesting:

Employee Signature: _____ **Date:** _____

Liaison Comments:

Agency Liaison Signature: _____ **Date:** _____

FOR ADOA USE ONLY

APPROVED DENIED DATE _____ REVIEWER: _____