

ENROLLMENT, ELIGIBILITY OR HCRA APPEAL SUBMISSION FORM

ASEA Health Benefits Trust

Address: 111 W. Cataldo, Suite 220, Spokane, WA 99201 • Phone: 866-553-8206 (toll-free); 509-328-0300 • Fax: 509-328-8623

Website: www.aseahealth.org

Use this form to submit an appeal for an enrollment, eligibility or HCRA appeal. Enrollment and HCRA appeals must be submitted in writing to the Board of Trustees, in care of the Health Trust Administrator at the above address within 45 calendar days after the first payroll to which the enrollment applies. Please see your Plan Booklet for complete details about the appeal process and applicable time limits.

The deadline for submitting enrollment, eligibility or HCRA appeals is within 45 calendar days after the first payroll to which the enrollment applies.

Please complete the section below that pertains to your appeal and fax the form and documentation to the ASEA Health Trust Administrator at the above number or mail it to the address shown.

PLEASE PRINT CLEARLY

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|---|--|
| Employee name: | SSN or Alternate ID: |
| Email (optional): | Phone #: |
| Mailing address: | |
| Enrollment type: <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> HCRA <input type="checkbox"/> Other: | |
| Date enrollment submitted: | Online: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hire date: | Date of 1st payroll deduction: |
| Date enrollment submitted: | Online: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appeal reason: <input type="checkbox"/> Default to Plan A <input type="checkbox"/> Other: | |

Please state below the reasons why your appeal should be granted, including a summary of the facts. Cite Plan provisions that support your reasons and attach all supporting documentation for your appeal. If necessary, you can attach a second page to this form.

Signature of Employee:

Date: