

Active Employee Appeal Request Form - 2016 Enrollment

An appeal is a request from an employee and/or agency requesting an eligibility exception due to an error in enrollment or an extenuating circumstance.



Step 1:

In order to appeal an eligibility issue, please complete this form and provide it to your agency's benefit liaison. The agency benefit liaison should review the appeal and add any comments the liaison believes are relevant.

Step 2:

The benefit liaison should submit this form along with supporting documentation and a copy of a completed 2016 Enrollment Form to ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 ATTN: Member Services - Appeals or fax to: 602-542-4744 or email to: benefitsissues@azdoa.gov, Subject: "2016 Appeal Last Name EIN" for example, "2016 Appeal Smith 000001"

Please check off 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 enrollment | <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 Service. You and/or agency may appeal the adverse decision related to your coverage.

Name (Last)	(First)	(MI)	Employee EIN	Last 4 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: _____