

**Purpose of Appeal Form**

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

**Section A: Member Information**

LAST NAME		FIRST NAME		M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER-LAST 4 DIGITS	BIRTH DATE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
MAILING ADDRESS		CITY	ST	ZIP
HOME PHONE		CELL PHONE	EMAIL	
AGENCY				

**Section B: How To Appeal**

<p><b>Step 1: Employee</b></p> <p>1) Required: Complete this form. 2) Required: Complete the 2024 Active Benefits Enrollment form. <i>Find form on <a href="http://benefitoptions.az.gov/forms">benefitoptions.az.gov/forms</a></i> 3) As applicable: Include supporting documentation. 4) Required: Give all materials to your agency's benefit liaison. <i>Note: Appeals with incomplete documentation will be delayed.</i></p>	<p><b>Step 2: Benefits Liaison</b></p> <p>1) Review the appeal form and make any additional comments. 2) Submit all employee materials to ADOA.</p>		
	<table border="1"> <tr> <td> <p><b>Mailing Address</b> ADOA-Benefits Attn: Member Services-Appeals 1802 W. Jackson St, #94 Phoenix, AZ 85007</p> </td> <td> <p><b>Email</b> benefits@azdoa.gov Subject: "2024 Appeal"</p> <hr/> <p><b>Fax - 602-542-4744</b></p> </td> </tr> </table>	<p><b>Mailing Address</b> ADOA-Benefits Attn: Member Services-Appeals 1802 W. Jackson St, #94 Phoenix, AZ 85007</p>	<p><b>Email</b> benefits@azdoa.gov Subject: "2024 Appeal"</p> <hr/> <p><b>Fax - 602-542-4744</b></p>
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**Section C: Appeal Reason**

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

<input type="checkbox"/> Missed Open Enrollment for 2024.	<input type="checkbox"/> Did not enroll during New Employee Enrollment period.
<input type="checkbox"/> Error with enrollment. Provide confirmation.	<input type="checkbox"/> Request for change submitted more than 31 days after eligible date.
<input type="checkbox"/> Extenuating circumstances.	

**Is this a second appeal?** *If yes, an appeal is a request to change a previous adverse decision made by ADOA-Benefits.*  
 YES  NO *You may appeal the adverse decision related to your coverage.*

**Section D: Appeal Explanation**

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

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Liaison Comments:**

Liaison Signature: \_\_\_\_\_ Date: \_\_\_\_\_