ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

EMPLOYEE ENROLLMENT APPEAL REQUEST FORM 2019

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	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED
STREET		CITY	ZIP	AGENCY
HOME PHONE	CELL PHONE		EMAIL	

Section B: How To Appeal

Step 1: Employee	Step 2: Benefits Liaison
1) Complete this form **2)** Gather supporting documentation as applicable **3)** Complete 2019 Active Benefits Enrollment form **4)** Give all materials to your agency's benefit liaison	1) Review the appeal form and make any additional comments 2) Submit all employee materials from Step 1 to ADOA **Email:** benefitsissues@azdoa.gov, Subject: 2019 Appeal, Last Name, EIN | **FAX:** 602-542-4744 **Mail:** ADOA-Benefit Svcs, Attn: Member Svcs-Appeals, 100 N. 15th Av, Ste. 260, Phoenix, AZ 85007

Section C: Appeal Reason

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

- ❑ Missed Open Enrollment for 2019
- ❑ Error with enrollment. Provide confirmation.
- ❑ Extenuating circumstances in which elections must be changed
- ❑ Did not enroll during New Employee Enrollment period
- ❑ Request for change submitted more than 31 days after eligible date

Is this a second appeal? ❑ **YES** ❑ **NO**

If yes, an appeal is a request to change a previous adverse decision made by ADOA-Benefit Services Division. 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:____/____/____

ADOA USE: ❑ **Approved** ❑ **Denied** **Date:** ____/____/____ **Reviewer:** _____