BENEFITS APPEAL FORM

July through December 2020 Wellness Incentives

Employee Name: _____ _____
Please Print Last Name, First Name **Date of Birth**

Employee Phone (Work): _____**(Home)**_____ **E-mail**_____

Home Address: _____

Please provide a brief statement detailing the reason for your appeal. Attach documentation in support of your appeal. Documentation would include, but is not limited to, confirmation pages or documents printed from the web site showing dates of completion of activities. <u>DO NOT</u> provide specific personal health information for HIPAA compliance purposes:

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Signature **Date**

By signing this disclaimer, you authorize The Benefit Appeal Committee to investigate the issue detailed above. Timing of the final decision on your appeal will vary based on the complexity of your issue. Appeals must be submitted by no later than May 31, 2021 in order to be considered. <u>ALL APPEAL DECISIONS ARE FINAL.</u>

FAX OR E-MAIL THIS FORM TO
937-496-7407 or HR@MCOHIO.ORG
ATTN: Benefits Appeal Committee