DENTAL AND VISION APPEAL FORM FOR UNION REPRESENTED EMPLOYEES

MEMBER INFORMATION

NAME_____ State of Ohio User ID _____ DATE_____

Please provide information where you can be reached regarding your appeal:

EMAIL_____ PHONE_____Best time to call_____

REASON FOR APPEAL_____

_____

DEPENDENT(S) **EVENT DATE**

You must provide all required forms and documentation to your agency. Documentation must include the UBT Enrollment Form and ALL dependent documentation requirements as outlined at das.gov/eligibilityrequirements.

MEMBER CONFIRMATION/CERTIFICATION

I certify that the above information and provided documentation to be accurate and that my dependents and I meet all eligibility criteria. I understand that providing false information may result in loss of coverage.

_____

Signature Date

AGENCY VERIFICATION

Please confirm that the employee has submitted and you have **on file all forms and required documentation** to confirm eligibility and provide coverage to the employee and his/her dependents.

Agency/ Benefit Specialist_____/_____Phone Number_____

Date forms received_____ Signature_____ Date_____

Comments_____

_____

Email completed form to: UBTAPPEALS@benefitstrust.org with MEMBER'S NAME in SUBJECT BOX

- **A confirmation email will follow upon receipt**

FOR OFFICE USE ONLY

☐**APPROVED** ☐**DENIED DATE**_____ ☐ **DAS ADVISED: DATE**_____

☐**MEMBER NOTIFIED DATE**_____ ☐**EMAIL** ☐ **USPS**