# 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/eligibility requirements.

**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**. Please submit form and documents to UBT.**

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**