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 ____

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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 HUMAN RESOURCES DEPARTMENT 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 your Agency Human Resources Department**.

Agency/ Benefit Specialist____________/______________________Phone Number______________

Date forms received: __________ Signature: ______________________ Date: ____________

Comments: ____

Agency Recommendation: ______________________

Email completed form to: Your Agency HR Department and the AGENCY will forward 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**