



Late Self-Payment Request/Appeal Form

PARTICIPANT INFORMATION

Participant Name _____
 Social Security # _____
 MID # _____ Plan # _____
 Address _____
 Phone Number _____

EMPLOYER/APEAL INFORMATION

Employer _____
 Date of Appeal _____
 Base Month (based on hours/day(s) worked) _____
 Coverage Month/Month of Appeal _____

PLEASE WRITE YOUR APPEAL LETTER/EXPLANATION BELOW

To the Appeals Subcommittee: _____

Signature _____

For Office Use	TYPE	<input type="checkbox"/> Self payment <input type="checkbox"/> Retiree dental/medical <input type="checkbox"/> IPNL/EDNL/D&L	<input type="checkbox"/> Employee contribution <input type="checkbox"/> DP tax payment	<input type="checkbox"/> COBRA <input type="checkbox"/> Disability
	GRANT	<input type="checkbox"/> First appeal in 12 months <input type="checkbox"/> Wrong address	<input type="checkbox"/> Second appeal in 12 months <input type="checkbox"/> Physical/mental incapacity	<input type="checkbox"/> Lag months <input type="checkbox"/> Away from residence
	REFUSE	<input type="checkbox"/> Third appeal in 12 months <input type="checkbox"/> Max eligibility	<input type="checkbox"/> Exceeds 12 month rule <input type="checkbox"/> Self-pay abuse	<input type="checkbox"/> NSF
	OTHER	_____		
	PAYMENT	<input type="checkbox"/> Check (# _____)	<input type="checkbox"/> Money Order	<input type="checkbox"/> Credit Card