EVERETT SCHOOL EMPLOYEE BENEFIT TRUST
APPEAL FORM

DATE: _____

NAME: _____
ADDRESS: _____
_____

TO: TRUSTEES OF EVERETT SCHOOL EMPLOYEE BENEFIT TRUST

RE: (Check One)

☐ APPEAL OF BENEFIT DENIAL BY HMA/PCN

☐ APPEAL OF ELIGIBILITY/ENROLLMENT DENIAL BY THE EVERETT SCHOOL DISTRICT

1. Date notified of denial _____.
This date is within 180 days of the notification of the denial.

2. Please attach all documentation pertaining to the benefit or enrollment/eligibility denial. The following documents are attached: (Please list)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

3. Please describe in your own words the reason you are appealing the benefit or enrollment/eligibility denial. You can use the space below or attach a separate document.

4. _____ _____
Name Date

_____
Signature (or signature of authorized representative)