

APPEAL OF BENEFIT DENIAL
TO THE BOARD OF TRUSTEES OF THE
LOCAL 309 ELECTRICAL HEALTH AND WELFARE FUND

Instructions: Complete the following form and return it to the Fund Office for an appeal of a benefit denial. If you need additional space, you may add additional pages. Also, attach copies of any pertinent material regarding your appeal. Please print.

Employee Name: _____

Employee Social Security Number: _____

Patient's Name and Relationship to Employee: _____

Date of Claim: _____

Briefly Describe Your Claim for Benefits: _____

Why Do You Believe Your Claim for Benefits Was Denied? _____

Why Do You Believe Your Claim For Benefits Should Be Paid? _____

Date: _____

Signature: _____