USW 8782
RETIREE BENEFITS TRUST

CLAIM APPEAL FORM

Please complete, print, sign and return this form to Terry Barnard, Plan Administrator. **Please PRINT clearly.**

1. APPEAL DETAILS

I hereby appeal denial of the following claim:

Claimant First name, Middle initial, Last name		
Member identification number	**Claim number** (assigned by office)	**Type of appeal** (health, dental, etc.)
Reason for denial		
Reason for appeal (attach details to this form, if needed)		
Claim expenses being appealed (please provide dates of expenses and attach copies of any cost estimates or other backup from your providers)		

2. AUTHORIZATION AND SIGNATURE

Important: YOU MUST SIGN AND DATE THIS FORM

I request a review under the USW Local 8782 ELHT. I agree that the trustees, plan administrator, any independent physicians, evaluators, agents and consultants acting on behalf of the USW Local 8782 ELHT may obtain or view, for the purposes of review only and from any source whatsoever, a copy of records respecting the matter under review. I also agree that the trustees, plan administrator., any independent physicians, evaluators, agents USW Local 8782 ELHT and consultants may disclose information related to this review to the other parties to this review for the express purposes of this review. I understand that it is a serious offence to knowingly provide false information in order to induce the Trustees to make a particular decision.

I hereby consent to and authorize any insurance company, licensed physician, health care practitioner, hospital, clinic, medical facility or organization that has records or information with regards to this appeal to release the information to the trustees, plan administrator, any independent physicians, evaluators, agents, USW Local 8782 ELHT and consultants acting on behalf of the USW Local 8782 ELHT, for its consideration of my claim appeal. A photocopy of this signed appeal and authorization shall be as valid as the original and shall continue to have effect through the duration of this appeal.

I hereby also agree to provide any additional information that may be requested for my claim appeal.

Member's Signature			**Date (dd-mm-yyyy)**
Address (street number and name)		**Apartment or Suite**	**City**
Province	**Postal Code**	**Telephone**	**Email Address**

If you have any questions or are unclear about what information to provide, please contact Terry Barnard, plan administrator at 519-587-2000 x225

The Board of Trustees has the sole authority to apply and interpret the terms of the Plan. The decision of the Board of Trustees concerning this appeal will be final and binding.

Return to:

Administrator
Email: admin@8782retireebenefitstrust.ca

OR

Administrator
P.O. Box 220
Jarvis, Ontario N0A 1J0