

**PUBLIC EMPLOYEES' BENEFIT BOARD  
APPEAL FORM**

To initiate an appeal, complete this form, attach supporting documentation, and mail or fax to:  
PEBB, 775 Court Street NE, Salem, OR 97301: (503) 373-1654

SUBSCRIBER INFORMATION - PLEASE TYPE OR PRINT CLEARLY				
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER	
MAILING ADDRESS: STREET		CITY	STATE	ZIP CODE
AGENCY NAME	AGENCY NUMBER	DAYTIME PHONE NUMBER	HOME PHONE NUMBER	E-MAIL ADDRESS

BENEFIT ISSUE (Please check all boxes that apply to this appeal)	
<input type="checkbox"/> MEDICAL CARRIER AND PLAN NAME	<input type="checkbox"/> DENTAL CARRIER AND PLAN NAME
<input type="checkbox"/> STANDARD LIFE & DISABILITY PROGRAMS (Check all applicable boxes) <input type="checkbox"/> Employee Basic Life <input type="checkbox"/> Accidental Death & Dismemberment <input type="checkbox"/> Dependent Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Employee Optional Life <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Spouse/Domestic Partner Optional Life	<input type="checkbox"/> BENEFITHELP SOLUTIONS (BHS) <input type="checkbox"/> COBRA Coverage <input type="checkbox"/> Retiree or Survivor Coverage <input type="checkbox"/> Self-Pay or Semi-Independent Agency Coverage
<input type="checkbox"/> HEALTHCARE or DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (BenefitHelp Solutions – BHS) <input type="checkbox"/> Change or new midyear enrollment (PEBB approval required)	<input type="checkbox"/> LONG TERM CARE INSURANCE

This appeal is for:     Enrollment Issue                       Eligibility Issue                       Reimbursement or Claim Issue  
                                   Customer Service Issue             Quality of Care Issue               Other \_\_\_\_\_

NOTE: If this appeal involves an enrollment change, attach appropriate forms for PEBB review. (Examples: Enrollment or update forms for Medical & Dental, Life & Disability, Flexible Spending Account or Long Term Care). If approved, the forms will be forwarded to payroll for implementation.

**STEP 1** Describe your request and reason for this appeal. Please include any pertinent information. If you require more space to present your problem, attach additional sheets.

**STEP 2** What steps have you taken to resolve this issue?

**STEP 3** What do you believe is a satisfactory resolution?

SUBSCRIBER SIGNATURE AND AUTHORIZATION	
Signature provides authorization to obtain additional information. A copy of this inquiry may be sent to the insurance carrier or agency involved.	
Signature _____	Date _____
PEBB Approval and Date _____	Applicable Rule _____

***Keep a copy of this form for your records.***