HOSPITALITY PLAN
UNITE HERE HEALTH

Late Self-Payment Request/Appeal Form

PARTICIPANT INFORMATION

Participant Name _____

Social Security # _____

MID # _____ Plan # _____

Address _____

Phone Number _____

EMPLOYER/APPEAL 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	o Self payment o Retiree dental/medical o IPNL/EDNL/D&L	o Employee contribution o DP tax payment	o COBRA o Disability
GRANT	o First appeal in 12 months o Wrong address	o Second appeal in 12 months o Physical/mental incapacity	o Lag months o Away from residence
REFUSE	o Third appeal in 12 months o Max eligibility	o Exceeds 12 month rule o Self-pay abuse	o NSF
OTHER	_____		
PAYMENT	o Check (# _____)	o Money Order	o Credit Card