Clovis Unified School District Health Plan
Appeal Form

Name (Please Print): ____

Employee Identification Number: ____

School Site/Department____

Reason for Appeal: Dependent Verification Audit Not Approved

Dependents Not approved:

Dependent ___________________________________ Relationship _______________

Dependent ___________________________________ Relationship _______________

Dependent ___________________________________ Relationship _______________

Dependent ___________________________________ Relationship _______________

Dependent ___________________________________ Relationship _______________

Dependent ___________________________________ Relationship _______________

Reason Appeal Should Be Approved : _______________________________________

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This appeal will be forwarded to the Appeal Committee for review. You will receive written notification of the decision made regarding your appeal no later than August 1, 2012.

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Employee's Signature Date