

Clovis Unified School District Health Plan Appeal Form

Name (Please Print): _____

Employee Identification Number: _____

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 : _____

This appeal will be forwarded to the Standing Benefits Committee for review. You will receive written notification of the decision made regarding your appeal no later than December 18, 2009.

Employee's Signature

Date