NECA-IBEW Pension Trust Fund

2120 Hubbard Avenue • Decatur, IL 62526-2871
217-875-0254 • 800-765-4239 • Fax 217-875-9563

NECA
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION

REQUEST FOR REVIEW OF AN ADVERSE BENEFIT DETERMINATION

Please complete (in printing) this adverse benefit determination appeal form and return to: Attention: Appeals Committee, NECA-IBEW Pension Trust Fund, 2120 Hubbard Avenue, Decatur, IL 62526-2871. You have **up to but not more than** 60 (180 for disability) calendar days after receipt of the written denial notice to decide whether you wish to file an appeal.

Participant's name: _____

Participant's social security number: _____

Participant's address: _____
Street and/or P.O. number

_____
City State Zip

Participant's telephone number: _____
Home (Area Code + Number) Work

Patient's E-mail address: _____
(ONLY IF YOU CONSENT TO BEING CONTACTED VIA E-MAIL)

_____ _____
Signature of Participant or Participant's Representative Date

Please state the benefits being denied:

_____

_____

_____

What are the reason(s) you feel the original decision was incorrect and that the benefit should be approved?

_____

_____

_____

_____

You may submit additional pages, if necessary. Also, submit all written comments, documents, records and other information relevant to the denied benefits.

You have the right to have this appeal decided on the basis of your written information, to appear in person before the individuals involved in reviewing your appeal, or to authorize an individual to present all of your information, or both.

Any expenses incurred in connection with your appeal by you, or on your behalf, will be your responsibility.

After we receive your Request for Review of an Adverse Benefit Determination form, you will be notified (by one or more methods) in writing, by telephone, facsimile, e-mail or any other expeditious method, of the date, time and location that your appeal will be discussed.

NECA-IBEW
PENSION TRUST FUND
2120 HUBBARD AVENUE • DECATUR, ILLINOIS 62526-2871 • TELEPHONE: (217) 875-0254

AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPEAL OF AN ADVERSE BENEFIT DETERMINATION

SECTION A: MUST BE COMPLETED BY PARTICIPANT OR PARTICIPANT'S REPRESENTATIVE

I hereby authorize the use or disclosure of my individually identifiable information to those individuals listed below. I understand that this authorization is voluntary.

Participant's name:_____

Participant's Social Security Number:_____

Specific description of benefit(s) being denied:

_____

_____

_____

Persons to whom disclosure will be made:

2 Union and 2 Employer Trustees of NECA-IBEW Pension Appeals Committee
Fund Administrator and/or designated representative
Fund Legal Counsel
Fund Consultant

Section B: NECA-IBEW Pension Trust Fund has requested this authorization due to the Fund's policy of not disclosing Individual identifiable information without written consent from the participant.

Section C: Must be completed by the participant or participant's representative

The participant or participant's representative must read and initial the following statements:

1. I understand that the payment of benefits will not be affected if I do not sign this form. Initials:_____

2. I understand that I may see and copy the information described on this form if I ask for it and that I receive a copy of this form after I sign it. Initials:_____

3. I understand that I may revoke this authorization at any time by notifying NECA-IBEW Pension Trust Fund in writing, but if I do it won't have any affect on any actions taken before NECA-IBEW received the revocation. Initials:_____

4. I understand I may terminate this authorization on a specific date. This authorization will expire on ____/____/____ Initials:_____

Signature of participant or participant's representative: _____

Printed name of patient's representative: _____

Relationship to the participant: _____

FORM MUST BE COMPLETED BEFORE SIGNING!

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

NECA-IBEW

PENSION TRUST FUND

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AUTHORIZATION FOR DESIGNATION OF REPRESENTATIVE FOR APPEAL OF AN ADVERSE BENEFIT DETERMINATION

This form must be completed if a participant wants an individual(s) to represent him/her regarding the denial of benefits listed below. This form authorizes NECA-IBEW Pension Trust Fund to share information in its possession with the designated representative listed below.

I hereby authorize the following individual(s) to represent me for a Review of an Adverse Benefit Determination:

*Representative's name:*_____

*Representative's name:*_____

This authorization is valid ONLY for the following denied Claim for benefit:

Describe the Benefit being denied:

_____

_____

_____

_____

Any expenses incurred in connection with your appeal by you and/or on your representative, will be your responsibility.

_____

Signature of Participant *Date*