# Enrollment Appeal Form – Broker

| Policy Holder's Name: | Date of Birth: | Member ID#: |
|---|---|---|
| | | |

| Broker Agency: | Name of Broker Submitting Appeal:<br><br>Group Name: |
|---|---|
| Phone #: | Email: |

**Dependent Name(s) if involved:**

**Who is the appeal regarding?**

**Who is at fault?**

Member
Group
Broker
Other: _______________________________

**Appeal Type:**

Late Enrollment
Retro Termination
Financial Hardship
Other: _________________________________

**Benefits Included in Appeal:**

Medical/RX
Dental
Vision
Other: _______________

**Explanation of Appeal:**

**Please acknowledge and initial the following:**

**If applicable, The group/member may owe back dated premiums.**
**If applicable, the group/member may owe recovery claims.**

**Please note:**
Appeals take up to 2 weeks to process. Please email this form to enrollment@emihealth.com to start the appeal process.

***Please provide any/all supporting documentation to support this appeal***

# Enrollment Appeal Form – Group

| **Broker's Signature:** | **Date:** |
| --- | --- |

***Please provide any/all supporting documentation to support this appeal***