Enrollment Appeal Form–Group

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

Company Name:	Name of Individual Submitting Appeal: Job Title
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:

Appeals are subject to approval or denial - We will let you know of the status via email.

- **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

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Employer's Signature:	**Date:**

Please provide any/all supporting documentation to support this appeal