Enrollment Appeal Form – Member

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

Phone #:	Email Address:

Mailing Address:

Dependent Name(s) if involved:

Who is the appeal regarding?

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 the outcome via email.

- **If applicable - you may owe back dated premiums**
- **If applicable - you may owe on 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.

Policy Holder's Signature: _____ **Date:** _____

Please attach any/all supporting documentation to support this appeal