IUOE Local 793

Appeal to Trustees' Appeal Committee

Pension and Benefits Administered by OEBAC

A Introduction

If after discussing with OEBAC a decision made about your benefits you are still not satisfied with its outcome, you can use this form to request the Plan Trustees to consider your case. Attach any additional pages used to describe the situation and desired resolution.

All appeals are in writing only and are dealt with by the Appeals Committee of the Board of Trustees. Before completing this form, please consult the Rules for Member Appeals on the OEBAC website. In the event of any inconsistency between this Form and the Rules, the Rules shall govern.

Please note that certain matters cannot be the subject of appeals and will not be considered. There is no appeal with respect to a denial of short term or long-term disability benefits, or if you have exceeded the lifetime maximum for health benefits. Further if a benefit cannot be lawfully provided by any of the respective funds, the appeal will be denied.

➔ **Note: All appeals to the Trustees must be submitted within 90 days from the date your claim was denied.**

B Plan Member's information

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ABCDEFGH

Full Name		From your OEBAC Benefits Card Group #: ☐ 793 ☐ 793X Certificate #:
Phone #	Email	Or, from your IUOE Local 793 Card Registration #:

C Appeal to denied payment of incurred expenses

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Type of denied expenses

- ☐ Drug and Supplementary Health Care Claim
- ☐ Dental Claim
- ☐ Parental Leave Claim
- ☐ Bereavement Claim
- ☐ Accidental Death Claim
- ☐ Dismemberment Claim
- ☐ Health Care Supplementary Account Claim
- ☐ Jury Duty/Subpoenaed Witness Claim
- ☐ **O**ther Group Legal Claim

When did the expense occur? (yyyy-mm-dd)	What is the amount in dispute? $

Was there a pre-authorization form approved? ☐ Yes ☐ No

If "Yes", when was the pre-authorization done? (yyyy-mm-dd)

D Additional information about this appeal

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When was the original request made? (yyyy-mm-dd)	When was the original request denied? (yyyy-mm-dd)

Use additional pages if you do not have enough space below.

Describe the situation leading to this appeal:
What would constitute a satisfactory resolution?

E Signature

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By signing below,

- I solemnly declare that the information provided on this form is accurate to the best of my knowledge.
- I authorize IUOE Local 793, the Fund Trustees, OEBAC and any of its service providers to use and disclose the provided information and any other information collected about me, my Dependants, or my Beneficiaries to process my benefits, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans.

Name of Plan Participant	Signature of Plan Participant	Date (yyyy-mm-dd)

Staple this form and all the attachments and mail them to

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON, L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to

info@oebac.org