

To Appeal a Termination of Your COBRA Eligibility or Enrollment

If you feel the non-commencement or termination of your benefits under the Federal COBRA regulations was in error, you have the right to file an appeal by writing a letter which explains why you believe the coverage should be reinstated.

Steps to Appeal

1. Your appeal must be submitted in writing and mailed or faxed to:

WageWorks, Inc.
Attn: COBRA Appeals
PO Box 3560
Vista, CA 92085-3560

Fax: (866) 672-3631

2. Your appeal must be received within 180 days of the date you receive notice that your COBRA coverage has been terminated or has not commenced.
3. You are welcome to submit additional information related to your coverage along with your appeal, such as: written comments, documents, records, or any other information you feel will support your claim.
4. You can request copies of all documents and information related to your COBRA benefits. These will be provided at no charge.

Appeal Review Process

- Your appeal will be reviewed by a person who was not involved with the initial coverage termination and who is not a subordinate of any person who was.
- The review will be a fresh look at your appeal without deference to the initial denial and will take into account all information submitted with your appeal.
- You will be notified of the decision regarding your appeal in writing by WageWorks within 30 days of receipt of your written appeal.

Please note: Appeals related to the denial of ARRA eligibility should be filed with the Department of Labor and will not be considered under this appeals process. In addition, written appeals regarding ARRA eligibility will not be responded to by WageWorks.

Participant Information			
Participant Name		Former Employer	
Participant ID Number		Email Address	
Mailing address			
City, State, Zip Code		Telephone	

Appeal Information			
COBRA Termination Date			
COBRA Termination Reason			
Reason for Appeal			
Appeal filed by (relationship to employee)	<input type="checkbox"/> Self	Names of Dependents also included in appeal	
	<input type="checkbox"/> Spouse		
	<input type="checkbox"/> Child		
	<input type="checkbox"/> Other		

Payments and Correspondence	
List all payments made for COBRA Coverage	
Payment Date(s)	Payment Amount(s)
List all letters received regarding COBRA Coverage	
Letter Date(s)	Subject of Letter(s)

Other information relevant to COBRA termination and/or appeal

Signature:	Date:
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Please mail or fax this form along with any other documentation you would like considered as part of your appeal to:

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