

Benefit Denial Intake Form

Last Name: _____ First Name: _____

SS#: _____ Local # _____

Home/Cell #: _____ Work/Pager #: _____

Home Address: _____

Title: _____ Dept. _____

Full or Part Time: _____ Email: _____

Type of Benefit Claim: _____

If DB – Physical Health _____ Mental Health _____ 1st Day of Absence _____

1st Day DB _____ Date Notified of Denial _____

Approval Date [if any] _____

Returned to Work Date [if any] _____

Treating Physicians Name _____ Dr. TN# _____

Specialty _____ Dr. Address _____

Explanation of Claim _____

Did Member File/Appeal to : SMAART _____ EEOC/ADA _____ NLRB _____

Did Member Request Accommodations _____ If Yes, What _____

Did ATT Reject _____ If So, Why _____

Did Member Request FMLA _____ Approved or Denied _____

If Rejected, Why _____

Local Benefit Rep Name/Local Lori Martin _____ TN# 989-793-4108

Local Benefit Rep Email lori@cwa4108.org _____ SBR Name D. McKenney

Did you attach release forms, medical documents, test results and denial letters?