Hawaii Employer-Union Health Benefits Trust Fund

APPEAL FORM

If appealing to the Administrator, appeal must be submitted to EUTF within 180 days of the adverse decision

If appealing to the Board, appeal must be submitted to EUTF within 90 days of the Administrator's decision

Name: _____

Address: _____

Contact Phone No: _____ Last 4 digits of SSN: _____

Email Address: _____

Nature of Appeal (describe in detail what you are appealing and attach any supporting documentation) Please include the following information:

- A description of the decision with respect to which you request relief, including the date of the decision.
- A statement of relevant and material facts.
- A statement as to why you are appealing the decision, including the reasons that support your position or contentions.
- A full discussion of the reasons, including any legal authorities, in support of your position or contentions.

I attest that the information provided in this appeal is truthful. I give EUTF permission to contact anyone associated with this appeal, including my personnel office, to investigate this appeal.

_____ _____

Signature of Appellant Date