DIOCESE OF CHARLOTTE

OFFICE OF HUMAN RESOURCES

Insurance Enrollment Appeal Request

The Diocese of Charlotte is committed to compliance with all requirements of the Catholic Diocese of Charlotte Flexible Compensation Plan, Internal Revenue Code Section 125, the Affordable Care Act, and the Health Insurance Portability and Accountability Act. The diocese will offer enrollment to employees when first eligible, during the annual Open Enrollment Period, and during a special mid-plan year enrollment period when allowable. The diocese will not tolerate discrimination in administration of insurance benefit plans.

If you are an eligible employee and have questions about your opportunities to elect coverage, contact Human Resources at 704-370-6299. You should complete this Insurance Enrollment Appeal Request form and submit it to Human Resources if you feel you have been wrongfully denied coverage. If you require help in completing the form, you may ask Human Resources for assistance. If you do not complete the form yourself, you should sign the form in the appropriate place and have the person that completed it sign in the appropriate place. This request form is a confidential medical form and will be kept separately from your personnel file. It is the duty of any employee to submit a request for a change in coverage on or within 30 days after a mid-year change in status occurs.

Employee Name:	**Date Requested:**
Phone Number:	**Location/Department:**
1. Explain the reason for your appeal: (e.g. add or remove coverage for self or dependent)	
2. In detail, please state the desired outcome you are requesting:	
If additional space is needed, please use the back of this form and/or additional sheets as necessary.	
3. Submit this appeal form with any supporting documentation to Human Resources:	
Fax to 704-370-3223 or email to HumanResources@rcdoc.org	
Mail to Human Resources, Attn: Enrollment Appeals, Diocese of Charlotte, 1123 S. Church Street, Charlotte, NC 28203	
The Diocese of Charlotte will review your confirmed appeal request. A response will be provided within 5-7 business days. Please be available for calls from Human Resources at the phone number you provided. If you are unable to be reached and do not enroll in a reasonable amount of time, your case will be closed and you will have to wait until Open Enrollment to change your insurance plan election.	

Employee Authorization: (required)
I acknowledge by signing this form that any change to my insurance plans and/or levels of coverage may affect my insurance deductions to my pay. For any missed benefit deductions that are a result of approval of this appeal, I authorize accelerated deductions for insurance premiums from my pay.

Employee submitting appeal:

_____

Print Name Signature Date

Person completing this form if different than that of Employee submitting appeal:

_____

Print Name Signature Date