



USW-Coastal Forest Industry Health & Welfare Plan

PO Box 24715, Stn. F, Vancouver, BC V5N 5T8

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LATE FILE / APPEAL FORM

_____ FIRST NAME	_____ LAST NAME	_____ PLAN ID NUMBER
_____ ADDRESS		_____ PHONE NUMBER
_____ UNION LOCAL	_____ UNION REPRESENTATIVE	_____ PHONE NUMBER
_____ EMPLOYER	_____ EMPLOYER CONTACT	_____ PHONE NUMBER
_____ JOB TITLE / OCCUPATION		_____ JOB STATUS (AVAILABILITY?)

What is the subject of your appeal? (Check one.)

- | | |
|---|---|
| <input type="checkbox"/> WI – Late File | <input type="checkbox"/> WI – Medical Adjudication |
| <input type="checkbox"/> WI – Rehabilitation Services | <input type="checkbox"/> Life Insurance Eligibility |
| <input type="checkbox"/> Other _____ | |

What specific decision are you appealing? _____

Why do you feel this decision should be changed? _____

Is there a specific remedy or course of action you wish the Trustees to consider? _____

Are you submitting additional documentation in support of your appeal? (Check one.)

- Documentation is attached
- Documentation will follow on or before _____ (Expected date)
- No further documentation will be submitted

Signature: _____	Date: _____
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**Please mail or email the completed form to the Trustees,
c/o the Plan Office at the above address**