



# USW-Coastal Forest Industry Health & Welfare Plan

c/o AGA Benefit Solutions

301E-675 Cochrane Dr Markham, ON L3E 0B8

Phone: 1-800-218-7018 | [uswcoastal@aga.ca](mailto:uswcoastal@aga.ca) | [uswcfibenefits.ca](http://uswcfibenefits.ca)

## 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

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