



Trustees of the Southern Interior Health & Welfare Plan

c/o Pacific Blue Cross*

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

☎: 604 419-2481 FAX: 604 419-2884 Email: admn@pac.bluecross.ca Web: <http://siw.planoffice.ca/>

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?

- WI - Medical Adjudication or
 WI- Rehabilitation Services or
 Dental Claim
 Extended Health Care Claim or
 Life Insurance Eligibility or
 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?

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

(Signature) _____ (Date) _____

Please mail, email or FAX the completed form to the Trustees,
c/o the Plan Office at the above address