

**CITY OF CHICAGO**  
**DEPARTMENT OF FINANCE - CHICAGO BENEFITS OFFICE**  
**APPEAL FORM**

**If you wish to appeal a decision made by the Benefits Service Center regarding you or a dependent(s) eligibility for benefits, you may submit a written appeal within 60 days after notification of the adverse decision. The Appeal form may be mailed to City of Chicago, Benefits Service Center, P.O. Box 9929, Providence, Rhode Island 02940-4029 or faxed to 312-747-8661.**

***Note: If you are considering emailing personal information to the Chicago Benefits Office, please be aware that email and other electronic communication can be intercepted in transition or misdirected. Therefore, please consider communicating sensitive information to the Chicago Benefits Office by secured fax or regular mail.***

EMPLOYEE NAME (LAST, FIRST, INITIAL)

EMPLOYEE ID #

Street Address

Street Address Line 2

City

E-mail Address

Daytime Phone Number

Home Phone Number

What is your preferred method of contact?

What are the best times to reach you?

Appeal is for?

If dependent - Provide Name, Relationship and Date of Birth

Self (City Employee)

Dependent

Retiree

Provide a brief statement of the reason you believe the determination of you or your dependents eligibility is wrong. Include any additional information that would help the Benefits Committee in reviewing the appeal.

Employee Signature

Date

**FOR INTERNAL CBO USE ONLY**

Initials/Signature

Date

Action Take

If Approved:

If Benefits Committee, date of meeting

Comments:

Approved

Administrative

Denied

Benefits  
Committee

Sent to CS