Dependent Verification Claim Initiation Form

To make an official appeal for reinstatement of coverage of a dependent(s) removed as a result of the Dependent Eligibility Verification Audit (DEVA), **you must complete and return all pages of this form, including submission of all documentation you feel supports your appeal to Alight Claims and Appeals Management. To ensure your request is received by Alight Claims and Appeals Management, click on the Claims and Appeals tab noted below.**

Keep a copy of this form and all submitted documents for your records. Upload all pages of this form along with any required documentation to:

Secure Online Upload: www.yourdependentverification.com/plan-smart-info
Click on the Claims and Appeals tab in order to ensure that your request is received.

Login Name - NJ + Your Dependent Verification ID. (Example NJ1234567)
Your Dependent Verification ID can be found at the bottom center of this page. **You Must Add the NJ PREFIX before your Verification ID**

Password - For first time users, this is the last 4 digits of your Social Security Number (SSN). (Example 1234)
You will be instructed to change your password upon entering the secured site.

If necessary, you may also fax or mail your request.
Secure Fax: 1-855-769-5781
Mail: Claims and Appeals Management, P.O. Box 1434, Lincolnshire, IL 60069-1434

When faxing your information, do **not** include a cover sheet. Only fax this form, followed by any documentation.

Acknowledgment and Signature

By my signature below, I formally file an appeal for reinstatement of coverage of the dependent(s) listed herein. I further acknowledge by my signature that I have reviewed and understand the information contained in this form and the information contained in the summary plan description for the aforementioned plan. I also understand that any rights under such plan are governed by the appeals procedures of the plan.

Please note that if approved, coverages will be retroactively reinstated, and retroactive deductions may apply.

_____ _____

Signature *Date*

Benefit or Coverage Requested

Please provide all information indicated below. If you do not complete this form, it may delay the determination of your request:

1. List the dependent(s) for which you are requesting reinstatement:

_____

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2. Please include any extenuating circumstances that you would like considered. Please include any documentation that could support the situation.

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_____

Appeals Procedure

Alight Claims and Appeals Management will send you a written notice of its determination of your appeal. You will receive this written notice within a 30-day time period.

If Alight Claims and Appeals Management denies your appeal, the written notice will provide you with the information to file a level II appeal.

If Alight Claims and Appeals Management needs additional time to process your appeal, you will receive a written notice of the need for an additional 15 days to process your appeal, the reasons for the longer period, and a date on which you can expect your appeal to be processed. The written notice of a longer processing period will be sent to you within the original time period Claims and Appeals Management had to process the appeal.

For More Information

If you have questions, please call the Dependent Verification Center at **1-833-372-8748**. The Dependent Verification Center is available between 8 a.m. and 11 p.m. Eastern Time, Monday through Friday.

Language Assistance

Help is available in Spanish. Please call 1-833-372-8748.
Se ofrece ayuda en español. Por favor, llame al 1-833-372-8748.