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