United Food & Commercial Workers Unions
and Food Employers Benefit Fund
6425 Katella Avenue • P.O. BOX 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715 • 877-284-2320 scufcwfunds.com

Appeal Form

Use this form to file an appeal of a claim for benefits which have been partially or wholly denied. You must file your appeal within 180 days (60 days for Death Benefit and Pension) of the date you receive the notice of denial from the Fund. It will facilitate the processing of your appeal if you attach the letter of denial you received to this form.

Appellant Information *Fill out this section if the appellant is not the participant. Please print clearly.*

Appellant's Last Name	First Name	M.I.	Social Security Number ___ - ___ - ____
Mailing Address	City	State	Zip Code

Participant Information *Fill out this section whether the appeal is for yourself or for a dependent. Please print clearly.*

Participant's Last Name	First Name	M.I.	Social Security Number ___ - ___ - ____
Mailing Address	City	State	Zip Code
Home Phone Number ( )	Date Of Birth	☐ Male ☐ Female	☐ Married ☐ Single
Employer	Work Phone Number ( )	Email Address	

Dependent Information *If this appeal is for a dependent, please complete this section.*

Last Name	First Name	M.I.	Date Of Birth	☐ Spouse ☐ Child

Type Of Appeal

☐ Medical	☐ Mental Health and Substance Abuse	☐ Death Benefit
☐ Dental	☐ Eligibility	☐ Pension
☐ Orthodontic	☐ COBRA	☐ Scholarship/Tuition Assistance
☐ Vision	☐ Plan Change	☐ Other_____
☐ Prescription		

Documentation Presented

Statement Of Facts *Use separate sheet of paper if necessary.*

Appellant's Signature D ate