NJDPB
Pensions & Benefits
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alight

CLAIMS & APPEALS MANAGEMENT
P.O. BOX 7121
RANTOUL, IL 61866-7122

Return Service Requested

Dear Ms. Test:

You recently requested the enclosed State of New Jersey Appeal Form. To initiate an appeal, please complete the attached form and upload it with the required documentation to the Alight Claims and Appeals Management team at the website below. Click on the **Claims and Appeals** tab to ensure that your request is received.

Secure Online Upload:
www.yourdependentverification.com/plan-smart-info
and click on the **Claims and Appeals** tab

Please see the Dependent Verification website for a list of required documentation.

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State of New Jersey Appeal Form Instructions

To make an official appeal under the SHBP/SEHBP, **you must complete and return all pages of this form.**

Please also include all documentation you feel supports your appeal to Claims and Appeals Management.

To ensure your request is received by Claims and Appeals Management, click on the Claims and Appeals tab to upload the completed Appeal Form and all documentation.

Keep a copy of this form for your records. Submit all pages of this form along with any documentation to:

Secure Online Upload: www.yourdependentverification.com/plan-smart-info

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: 1-855-769-5782
Mail: Claims and Appeals Management, P.O. Box 7123, Rantoul, IL 61866-7123

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

State of New Jersey Appeal Form

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 the appeal is for.

_____

_____

2. Please include any extenuating circumstances, other information or documentation that you would like considered in the review of this appeal. Please include any documentation that could support the situation.

_____

_____

_____

Acknowledgment and Signature

By my signature below, I formally file an appeal under the plan identified above. I further acknowledge by my signature that I have reviewed and understand the information contained in this form, the information contained in the summary plan description for the aforementioned plan, and any other plan related information previously provided to me. I also understand that any rights under such plan are governed by the appeal procedures of the plan.

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

_____ _____

Signature *Date*

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.