APPEAL FORM

Please complete all sections as it relates to your appeal.

NAME:

ADDRESS:

DAYTIME PHONE:

INSURED OR CLAIMANT (IF DIFFERENT FROM ABOVE):

CLAIM NUMBER:

POLICY NUMBER:

EMPLOYER:

DATE OF LOSS OR DATE CLAIM FILED:

CLAIM TYPE:

REASON FOR APPEAL: (attach additional documents if necessary)

Signature:_____ **Date:** _____

Attach all documentation and return to:

USABLE LIFE
ATTN: APPEAL COORDINATOR
PO BOX 1650
LITTLE ROCK, AR 72203-1650
FAX: 501-235-8484
EMAIL: APPEALCOORDINATOR@USABLELIFE.COM

Once an appeal coordinator has been assigned, that person may request that you submit additional information regarding your appeal and will also consider information submitted by others, including information from other USAble Life representatives. The appeal coordinator will send you a decision in writing concerning your appeal within the timeframe outlined in the terms of your insurance coverage. For questions regarding this process or for status of your appeal, please contact Customer Service at 1-800-370-5856 or custserv@usablelife.com.