AmericanAirlines®

EMPLOYEE BENEFIT COMMITTEE (EBC)
APPLICATION FOR SECOND LEVEL APPEAL: ADMINISTRATIVE ISSUES

THIS APPLICATION FOR SECOND LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING ISSUES OF ELIGIBILITY, ENROLLMENT, BENEFIT CHANGES SECONDARY TO LIFE EVENTS, BENEFIT CONTRIBUTIONS (INCLUDING PAYMENT OF CONTRIBUTIONS WHILE ON LEAVES OF ABSENCE), BENEFIT CHANGES OUTSIDE THE ANNUAL ENROLLMENT PERIOD, FSA ELECTIONS, ETC.

IMPORTANT NOTICE:

YOU MUST COMPLETE THIS FORM AND PROVIDE ALL REQUESTED INFORMATION; OTHERWISE, YOUR APPEAL CANNOT BE ACCEPTED FOR REVIEW BY THE EBC.

In order for the EBC to carefully review the facts and give every consideration to your issue, you must include all of the information requested below. Failure to provide all pertinent documentation may affect the outcome of this review. It is essential that you keep, for your records, copies of all documentation you submit in support of your Second Level Appeal. The information you submit is provided at your own expense. You must file this Second Level Appeal within 180 days of the date you receive notice of First Level Appeal determination letter from AON Benefits Service Center; otherwise, your right to further appeal is waived.

Your appeal must include the following:

- Complete, date, and sign this APPLICATION FOR SECOND LEVEL APPEAL (both employee and applicable dependent, other than a minor, must sign this Application)
- Attach a copy of AON Benefits service Center's First Level Appeal determination letter sent to you
- Explain, in detail, why you believe your issue in question should be approved by the EBC
- Include all information and documents that you believe support your appeal
- Attach copies of all applicable certificates (birth, marriage, divorce, adoption, etc.), documents (Jetnet screen-print, LOA forms, etc.), and all correspondence relating to your case
- If your issue involves previous discussions/communications, include the date(s), person(s) with whom you spoke, details of the conversation, copies of letters, etc.
- For Flexible Spending Account (Health Care FSA or Dependent Daycare FSA or Limited Purpose FSA) election issues, include copies of all correspondence from AON Benefits Service Center regarding this FSA account
- If you experienced any extenuating circumstances that you believe have a bearing on your appeal, include complete and specific details of such circumstances, and provide documentation to support the existence of such circumstances, and how they affected your case
- Other____

THIS WILL BE YOUR **FINAL** ADMINISTRATIVE REVIEW; THEREFORE, INCLUDE ALL FACTS AND CIRCUMSTANCES THAT YOU WANT THE EBC TO CONSIDER WHEN IT REVIEWS YOUR APPEAL. AFTER THE EBC RENDERS A DECISION ON YOUR SECOND LEVEL APPEAL, ADDITIONAL OR NEW INFORMATION WILL ***NOT*** BE CONSIDERED. THEREFORE, IT IS IMPERATIVE THAT YOU INCLUDE ANY AND ALL PERTINENT INFORMATION WHEN YOUR SECOND LEVEL APPEAL IS SUBMITTED.

EMPLOYEE'S SECOND LEVEL APPEAL:

The benefit(s) to which I believe I am entitled is/are as follows (describe the type of benefit and the circumstances involving your case, being as specific as you can). Please refer to the specific Plan provision from your **Employee Benefits Guide** that you believe entitles you to the benefits you are claiming (attach additional pages if needed):

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TOTAL AMOUNT OF APPEAL (IF KNOWN): $____________________

By signing this form, I attest to the validity of all information I have provided, and authorize the release of all clinical records and/or information pertinent to the evaluation of my appeal to American Airlines, Inc. Benefits Service Center, the Network/Claim Administrator, the Claim Processor, and the EBC at American Airlines, Inc., and its agents, including any health care professional selected by the EBC to assist with the appeal review. American Airlines, Inc. is the sponsor and administrator for the group health and welfare benefit plans.

PLEASE PRINT, SIGN, AND DATE THE FOLLOWING:

EE Name:	Benefit ID#:
EE#:	EE Signature:
SS#:	Patient Signature:
Address:	Date:
Address:	Home Phone:
City:	Work Phone:
State:	Cell Phone:
Zip:	Email:

MAIL (or use express delivery) COMPLETED FORM AND SUPPORTING MATERIALS TO:

FOR USPS REGULAR MAIL DELIVERY	FOR EXPRESS DELIVERY
Employee Benefits Committee	Employee Benefits Committee
American Airlines, Inc.	American Airlines, Inc.
PO BOX 619616 MD #5134-HDQ1	4333 Amon Carter Blvd. MD #5134-HDQ1
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