PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND
CLAIM APPEAL FORM

If, after submitting a written Request for Reconsideration to UMR, Inc. (UMR), your claim remains denied in whole or in part, you or your representative have the right to submit a written appeal, using this approved form, to the Board of Trustees within thirty (30) days after your claim is denied. Please complete this form and mail with all documentation not previously provided that may support your claim to: The Board of Trustees, Palm Beach County Firefighters Employee Benefits Fund, 2328 S. Congress, Suite 2C, West Palm Beach, Florida 33406. The Board will make a decision within sixty (60) days of receiving this appeal and will notify you in writing with the specific reasons for the decision.

Please Print Employee Name:
Name of Patient (if different):
ID Number:
Date of Illness or Injury:
Nature of Illness or Injury:
Please explain why this claim should be reconsidered (attach additional sheets if necessary): _____ _____ Signature of person requesting Appeal Date

Tracking information: (For Board use only)

Date Appeal received by the Board of Trustees:_____

Action by the Board of Trustees: [ ] granted [ ]denied

(Revised: 07/09/09)