Benefit Eligibility Appeal form

ATTN: R-02-B Long-Term Care
PO Box 852
Boston, MA 02117-0852
Phone: 800-233-1449 Fax: 617-572-7979

Insured Name : _____

Claim Number: _____

Introduction

This appeal form has been provided to help guide you or your designee through the appeal process. Please complete the following steps in order to initiate your appeal request:

- **Review the following elements from the denial letter:**
  a) Benefit Eligibility criteria description
  b) Sources on which John Hancock based the denial decision
  c) Detail John Hancock provided regarding the triggers that were not met
- **Make sure the insured name and claim number are provided in the space at the top of this form.**
- **Answer each question on this form and return it to the address above**

1. Reasons for Appeal

A. State the specific reason(s) you disagree with John Hancock's decision to deny benefit eligibility:

B. If applicable, describe the Activities of Daily Living with which you need assistance and the type of assistance needed.

Activity that Requires Assistance	Type of Assistance Required

Continued on Reverse ➔

C. If applicable, describe any cognitive impairment and the type of supervision you think is required as a result.

2. Additional Information

Describe any additional factors and/or pertinent clinical information that support the position you presented in Section 1A.

You may attach additional clinical information that supports your appeal.

3. Acknowledgement

This form was completed by:

☐ THE INSURED

☐ OTHER Relationship to Insured: _____

Before we can process this appeal, you need to certify by signing below that the information you have provided on this form is accurate and complete to the best of your knowledge and ability.

Sign Here

Signature **Date**

Print Name