AmericanAirlines®

EMPLOYEE BENEFIT COMMITTEE (EBC)

APPLICATION FOR SECOND LEVEL APPEAL: DISABILITY, PTD FOR LIFE INSURANCE

THIS APPLICATION FOR SECOND LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS (BENEFIT DENIAL, BENEFIT DISCONTUANCE, PLAN EXCLUSION, PREEXISTING CONDITIONS EXCLUSION, ETC.) INVOLVING DISABILITY BENEFITS (SHORT TERM, OPTIONAL SHORT TERM, LONG TERM) OR DETERMINATION OF PERMANENT AND TOTAL DISABILITY (PTD) FOR LIFE INSURANCE

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 copies, for your records, of all documentation you submit in support of your Second Level Appeal. The information you submit is provided at your own expense. The records submitted will be retained by the EBC. You must file this Second Level Appeal within 180 days of the date you receive notice of the First Level Appeal determination from the Claim Processor; otherwise, your right to further appeal is waived.

Your appeal must include the following:

- Completed APPLICATION FOR SECOND LEVEL APPEAL (employee must complete and sign this Application).
- 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 a copy of the First Level Appeal determination letter you received from the Claim Processor
- If your disability was due to a work-related injury, please provide all details and documentation, including Workers' Compensation documents and correspondence.
- Attach Explanation of Benefits Statements (EOBs) and correspondence you received from the Claim Processor regarding this issue
- Include a copy of your completed disability claim.
- Include a copy of your Social Security Disability Award notice (if applicable).
- Include physician clinical records and/or reports from all physicians that have *ever* treated you for this condition *or any condition* related to your disability.
- Include copies of hospital records (if applicable) for ***all*** admissions (current & prior) for this or *any other condition* related to your disability.
- Include copies of all therapy progress reports for all therapies you've received, such as physical, occupational, speech, chiropractic, acupuncture, etc., if related to your disability.
- Include a list of any medications you currently take (or have taken) and their dosages, that relate to your disability
- Send copies of documentation to substantiate any limitations/restrictions that affect your ability to return to work
- If your appeal involves denial of "permanent and total disability" status for life insurance, please submit copies of all correspondence you received from MetLife, and copies of the clinical records from your physicians
- 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_____

- **IF YOUR APPEAL INVOLVES A BENEFIT DENIAL BECAUSE OF A LATE CLAIM FILING ISSUE, PLEASE NOTE THAT ONLY THE FOLLOWING INFORMATION IS REQUIRED:**
    1) Completed APPLICATION FOR SECOND LEVEL APPEAL (must be completed and signed by Employee)
    2) A copy of the First Level Appeal determination letter you received from the Claim Processor
    3) A copy of the disability claim you submitted to the Claim Processor
    4) Full explanation of why you were unable to file your disability claim in a timely manner (within the plans' prescribed time limits for claim filing)
    5) A copy of any/all correspondence received from the Claim Processor, including a copy of its claim denial, and
    6) 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

Your failure to provide all pertinent documents may affect the outcome of your appeal review.

THIS WILL BE YOUR ***FINAL*** ADMINISTRATIVE REVIEW; THEREFORE, INCLUDE ALL FACTS AND CIRCUMSTANCES THAT YOU WANT THE EBC TO CONSIDER WHEN IT REVIEWS YOUR SECOND LEVEL APPEAL. AFTER THE EBC RENDERS A DECISION ON YOUR 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**, which you believe entitles you to the benefit(s) you are claiming (attach additional pages if needed):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 the Claim Processor, 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 Benefit Committee	**Employee Benefit Committee**
American Airlines, Inc.	**American Airlines, Inc.**
PO BOX 619616 MD #5134-HDQ1	**4333 Amon Carter Blvd. MD #5134-HDQ1**
DFW Airport, TX 75261-9616	**Fort Worth, TX 76155**
817-967-1412	**817-967-1412**