

Statement Date:



Benefits Service Center
my.aa.com



A000001

American Airlines

First Level Appeal Initiation Form

To make an official first level appeal under American Airlines "appeal procedures," as defined under Section 503 of ERISA (Employee Retirement Income Security Act), you must complete and return all pages of this form, including copies of any documentation you feel support your claim.

Acknowledgment and Signature

By signing below and returning this form, you're formally filing an appeal under the plan. Additionally:

- You confirm you've reviewed and understand the information contained in this form, the Summary Plan Description for the plan and any other plan-related information previously provided to you.
- You confirm you understand that any rights under such plan are governed by the appeals procedures of the plan.

By signing this form, I attest to the validity of all information I have provided, and authorize the release to **Claims and Appeals Management** of all clinical records and/or information pertinent to my appeal.

Employee Signature

Date

Dependent Signature, if not a minor

Date



This application for the first level appeal should be used to appeal adverse benefit determinations involving issues with 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, elections involving flexible spending accounts, etc.

Keep a copy of this form for your records. Then, mail or fax all pages of this original form (not a copy) along with any documentation to:

Fax:
1-847-554-1891

Mail:
Claims and Appeals Management
American Airlines
Post Office Box 1407
Lincolnshire, IL 60069-1407

When faxing your information, do **not** include a cover sheet. Only fax this form, followed by any documentation.

Foreign Language Assistance

Help is available in Chinese if you live in San Francisco County, CA. Please call 1-888-860-6178.

如果您居住在加州旧金山，可以获得中文协助。请于 1-888-860-6178。

Help is available in Tagalog if you live in Aleutians West Census Area and Aleutians East Borough Counties in AK. Please call 1-888-860-6178.

Mayroong makukuhang tulong sa Tagalog kung ikaw ay nakatira sa Aleutians West Census Area at sa Aleutians East Borough Counties sa AK. Pakitawagan 1-888-860-6178.

Help is available in Navajo if you live in Apache County, AZ, McKinley County, NM, or San Juan County, UT. Please call 1-888-860-6178.

Tah dine'keh ji' yahti gho shi'ka a'dol wol niin ziin gho' Dziil ghaa ii beh woo'ji ha'ghii (Apache County), Hoozdoh ji doo , Yooto' altsi'gho ha'da'haaszoo', ghii, (McKinley County, NM, or San Juan County, Ut), ee 'dii koh'ji' Ho'diil ni 1-888-860-6178.

Help is available in Spanish. Please call 1-888-860-6178.

Se ofrece ayuda en español. Por favor, llame al 1-888-860-6178.

Appeal Checklist

Before you send your completed form make sure:

- ✘ You signed and dated the form in the Acknowledgment and Signature section on the first page.
- ✘ You completed both sections of the Appeal Information section below.

- ✘ You responded to the three items in the Benefit or Coverage Requested section below.
- ✘ You provided **all** information about your appeal in the Benefit or Coverage Requested section below.
- ✘ You have any documentation supporting your appeal ready to be sent with this form.

If all of this information is not provided, your appeal will be denied and you'll need to submit your request again.

Appeal Information

This appeal is for:

Employee Name:

_____ *Last Name*

_____ *First Name*

_____ *Middle Initial*

Employee Number:

Address:

_____ *Street or P.O.Box*

_____ *City*

_____ *State*

_____ *Zip Code*

Dependent Name:

_____ *Last Name*

_____ *First Name*

_____ *Middle Initial*

Relationship to Employee:

Benefit or Coverage Requested

Please complete the three requests below, and fill out your appeal description on the next page. If you do not complete this form, it may delay the determination of your request.

1. Describe the specific benefits [(i.e. Medical, Dental, Vision, Pension, Savings, etc.)] that you and/or your dependent(s) are requesting to be eligible for or enrolled in.

2. If applicable, indicate the effective date (MM/DD/YY) you are requesting for eligibility, a change in benefits, etc.




3. What written and/or verbal information was provided to you that supports your request? When was the information provided?

In the blank table below:

- ✦ Provide a detailed description of your appeal, stating your issue or request.
- ✦ Include a statement of the reasons why you think you're entitled to such coverage or benefit.
- ✦ Attach a separate piece of paper, if you need additional space.

Provide Documentation

When you return this form, include any documentation you feel supports your appeal. Do **not** submit any original documentation. Documents submitted for appeal processing can't be returned to you.



Appeal Description

In order for Claims and Appeals Management 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 of all documentation you submit in support of your First Level Appeal, as this documentation will be required if you choose to file a Second Level Appeal. The information you submit is provided at your own expense. You must file this First Level Appeal within 180 days of the date you receive notice of the adverse benefit determination; otherwise, your right to both levels of appeal is waived.

- ✘ Complete, date, and sign this APPLICATION FOR FIRST LEVEL APPEAL (employee and applicable dependent, other than a minor, must sign this Application)
- ✘ Explain, in detail, why you believe your issue in question should be approved
- ✘ 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 Accounts (Health Care FSA or Dependent Daycare FSA) election issues, include copies of all correspondence from the American Airlines 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



Please do not submit any original documentation. Documents submitted for appeal processing cannot be returned to you.

If you need additional space, attach a separate piece of paper.

Appeal Procedure

The Summary Plan Description for the Plan which you're filing this appeal describes the appeals procedures.

Normally, Claims and Appeals Management will process your appeal within a reasonable period of time after receiving this form.

If Claims and Appeals Management needs additional time to process your first level appeal, you will receive a written notice of the need for a longer processing period, the reasons for the longer period, and a date on which you can expect your first level appeal to be processed. You'll receive written notice of a longer processing period within the original time period Claims and Appeals Management had to process the first level appeal under ERISA.

Claims and Appeals Management will send you a written notice of its determination of your appeal. You'll receive this written notice within the time period allowed under ERISA.



If Claims and Appeals Management denies your first level appeal, the written notice will provide you with the information required by ERISA. If you disagree with the First Level Appeal determination, you may appeal the decision by filing a Second Level Appeal with American Airlines, Inc. **HOWEVER, YOU MUST REQUEST A FIRST LEVEL APPEAL AND RECEIVE THE DETERMINATION BEFORE YOU MAY PROGRESS TO THE SECOND LEVEL APPEAL WITH AMERICAN AIRLINES.** If you wish to appeal to American Airlines, you must submit your request in writing and mail it, with a copy of the First Level Appeal determination letter, and all supporting documentation, to American Airlines. Your Second Level Appeal must be completed and filed within 180 days of the date you receive the decision on the First Level Appeal or your right to further appeal is waived.

For More Information



Online

Benefits Service Center
at my.aa.com



Phone

between 9 a.m. and 6 p.m., Central time, Monday through Friday
1-888-860-6178



Fax

1-847-554-1884
Cover letter not necessary



Mail

American Airlines Benefits Service Center
PO Box 64040
THE WOODLANDS, TX 77387-4040



