



Request for Review of Healthcare Coverage Eligibility

Please read prior to completing this form: This form is used to request a review of the healthcare eligibility determination and may be completed by an employee or the employee’s supervisor. Review outcomes will only be communicated to the employee who is the subject of the review. Once a determination has been made, the affected employee will be notified in writing of the findings. If eligibility is approved, the employee will be provided a Notice of Election form.

Please submit this form to: Sandy Butler in Human Resources by email at butlers@cofc.edu or by campus mail.

Employee Last Name			Employee First Name			MI	Employee ID (not SSN)
Name of person completing form (if other than employee)					<input type="checkbox"/> Employee completed form <input type="checkbox"/> Employee’s Supervisor completed form		
Street				Hire Date		Date of Birth	
City	State	Zip	Employee Email		Home Phone		Work Phone

Hours worked at all concurrent jobs within at College of Charleston during the 12-month measurement period are calculated and averaged. Provide information on all jobs worked during the measurement period to the best of your knowledge. Provide as much detail as possible to help in determining an employee’s hours worked between October 4th through October 3rd or if a new hire, during the 12 months after the hire date.

Job Title			Department				
Hours worked in this position are:							
<input type="checkbox"/> Same each week which are: _____							
<input type="checkbox"/> Vary week to week: From: _____ To: _____							
Supervisor				Supervisor Department			
Supervisor Phone Number				Supervisor Email			
Dates worked in this position: From: _____ To: _____							

Job Title			Department				
Hours worked in this position are:							
<input type="checkbox"/> Same each week which are: _____							
<input type="checkbox"/> Vary week to week: From: _____ To: _____							
Supervisor				Supervisor Department			
Supervisor Phone Number				Supervisor Email			
Dates worked in this position: From: _____ To: _____							

Job Title	Department
Hours worked in this position are:	
<input type="checkbox"/> Same each week which are: _____ <input type="checkbox"/> Vary week to week: From: _____ To: _____	
Supervisor	Supervisor Department
Supervisor Phone Number	Supervisor Email
Dates worked in this position: From: _____ To: _____	

Job Title	Department
Hours worked in this position are:	
<input type="checkbox"/> Same each week which are: _____ <input type="checkbox"/> Vary week to week: From: _____ To: _____	
Supervisor	Supervisor Department
Supervisor Phone Number	Supervisor Email
Dates worked in this position: From: _____ To: _____	

Job Title	Department
Hours worked in this position are:	
<input type="checkbox"/> Same each week which are: _____ <input type="checkbox"/> Vary week to week: From: _____ To: _____	
Supervisor	Supervisor Department
Supervisor Phone Number	Supervisor Email
Dates worked in this position: From: _____ To: _____	

If you need additional space to list jobs, please use an additional form.