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)	☐ Employee completed form ☐ 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: ☐ Same each week which are:_____ ☐ 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: ☐ Same each week which are:_____ ☐ 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: ☐ Same each week which are:______________________________ ☐ 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: ☐ Same each week which are:______________________________ ☐ 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: ☐ Same each week which are:______________________________ ☐ 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.