Toys“R”Us Benefit Claim for Eligibility / Enrollment

Second Level Appeal Process

To submit an official second level appeal under the Toys“R”Us benefit eligibility / enrollment procedure, as defined under Section 502 of ERISA, you must complete Sections 1, 2, 3, 4 and 5 of this form, and submit this form plus any supporting documentation that validates your statements to:

Toys“R”Us, Inc.
Benefit Eligibility / Enrollment Appeal
One Geoffrey Way L2N152
Wayne, NJ 07470

Section 1 – Appeal Procedure:

The Administrative and Legal Summary Plan Description (SPD) is located on www.RUsBenefits.com and describes the claims and appeal procedures. Toys“R”Us will make an appeal determination within 60 days after receiving this form and any supporting documentation. You will receive a written notice of its determination.

If Toys“R”Us requires additional time to make an appeal determination, you will receive a written notice advising of the need for additional review of the appeal, and a date on which you can expect an appeal determination to be made. You will receive written notice of its determination.

In order to obtain a copy of the Administrative and Legal Summary Plan Description (SPD), please access www.RUsBenefits.com website. (Username: RUS – Password: benefits)

Section 2 – Plan Information:

Select the appropriate category that your appeal relates to, please only select one category from the below list:

- □ **Enrollment / Eligibility***
- □ **Annual Enrollment****
- □ **Health Savings Account (HSA) / Flexible Spending Accounts (FSA) Claim**
- □ **Medical / Dental / Vision Claim**
- □ **Life Insurance / AD&D Claim**
- □ **Long Term Disability Claim**
- □ **Dependent Eligibility Verification**
- □ **Wellness Program Eligibility**
- **Other: ___________________**

***Select this category if you are appealing enrollment / eligibility for a Qualified Life Event outside of Annual Enrollment for the following benefits: Medical, Dental, Vision, Health Savings Account, Limited Purpose Flexible Spending Accounts, Supplemental Benefits, Life Insurance Benefits, Supplemental Long Term Disability Insurance, Evidence of Insurability (EOI)**
****Select this category if you are appealing enrollment / eligibility for an Annual Enrollment event for the following benefits: Medical, Dental, Vision, Health Savings Account, Limited Purpose Flexible Spending Accounts, Supplemental Benefits, Life Insurance Benefits, Supplemental Long Term Disability Insurance; Evidence of Insurability (EOI)**

Section 3 – Team Member Information (Please print)

Last Name	**First Name**	**Middle Initial** (if applicable)

Team Member ID: ______________________________

Home Address: ______________________________

Street

____

City State Zip Code

____

Phone Number Email Address

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If the appeal involves any of your dependents, please list the dependent names, relationship to you and dates of birth for each dependent (for additional space, please use separate piece of paper):

Dependent 1:			
(Please print)	Name (Last, First MI)	Relationship	Date of Birth
Dependent 2:			
(Please print)	Name (Last, First MI)	Relationship	Date of Birth
Dependent 3:			
(Please print)	Name (Last, First MI)	Relationship	Date of Birth

Section 4 – Reason for filing the appeal (Please print)

Please provide a description of the nature of your claim (e.g., reimbursement for medical expense, services covered by provider, eligibility of coverage) and a statement of the reasons why you think you are entitled to such coverage or benefit. Also, enclose with this form all supporting documentation of your claim. ***If you need additional space, attach a separate piece of paper.***

Section 5 – Claimant Acknowledgement and Signature:

By my signature below, I formally file a claim under the plan identified above. I further acknowledge by my signature that I have reviewed and understand the information contained in this form, the information contained in the Summary Plan Description for the aforementioned plan, and any other plan-related information previously provided to me. I also understand that any rights under such plan are governed by the claims procedures of the plan.

I acknowledge that, prior to submitting this Benefits Claim Appeal Form, I have had an opportunity to review relevant plan documents (available on RUsBenefits.com (ID: RUS – Password: benefits) for the benefit plan identified above. I understand that I will receive a decision in writing. If my appeal is denied, I will be told the specific reason or reasons for the denial, with references to the plan provisions on which the decision is based. I further understand that, if my appeal is denied, I am entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the denial of my claim. I certify that the information that I have supplied in connection with this appeal is true.

Team Member Signature Date

Team Member (Print Name)