AEOA
Options Blue/HSA
Hardship Appeal Request Form

Date:

Name:

Department:

Job Title:

Phone: Email:

Plan Coverage

☐ Single ☐ Family

Reason for Request

☐ Pharmacy cost expected to exceed

$ by Date:

☐ Other Medical Costs expected to exceed

$ by Date:

☐ Combined Pharmacy and Medical costs expected to exceed

$ by Date:

Employee Signature: Date:

HR Director Signature: Date:

Employee Disclaimer: In the event I am granted an advance on my HSA account, I understand I am obligated to repay AEOA the full amount of the advance if I am not employed by AEOA long enough during the year to have been entitled to the payments which were advanced. AEOA retains the right to verify the hardship need by requesting documentation of medical costs.