Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Use of this form is optional. A letter providing the same information is equally acceptable.

APPEAL FORM

Please print or type.

EMPLOYEE INFORMATION	EMPLOYER INFORMATION
Member Identification Number	Name
Name	Address
Mailing Address	
City, State, Zip	City, State, Zip

I appeal the determination regarding my:

- ☐ Beneficiary Designation
- ☐ Category of Employment
- ☐ Final Annuity Calculation
- ☐ Forfeited Service
- ☐ Military Service
- ☐ Participation in the Wisconsin Retirement System
- ☐ Separation Benefit
- ☐ 40.63 Disability Benefit
- ☐ 40.65 Disability Benefit
- ☐ Income Continuation Insurance
- ☐ Long-Term Disability Insurance
- ☐ Health Insurance
- ☐ Life insurance
- ☐ Wisconsin Deferred Compensation Program
- ☐ Other _____.

If health insurance is involved; name of insurance company: _____.

Date of the determination letter (from the Department):_____.

Please explain the factual and legal basis for the appeal, and why you believe the Department's determination is incorrect. You can attach any additional information that you believe is relevant.

_____

_____

_____

_____

_____

Date (MM/DD/CCYY)	Signature
Email Address	Daytime Telephone Number

Return completed Appeal Form to: Department of Employee Trust Funds, Attn: Appeals Coordinator, P.O. Box 7931, Madison, WI 53707-7931. Fax (608) 267-0633.