# Reconciliation Escalation Form (Requests greater than 90 days)

**Send completed form to:** **USGfinancialmanager@alight.com**

**Institution:** Please enter Employee name/Employee ID and information in bullet format

**Person Requesting:**

**Employee Name/ID:**

## Reason for Request (To be completed by institution)

[ ]  HR Data Related Changes >90 days

[ ]  Confirm effective date of transaction:

[ ]  Deceased Employee – Date:

[ ]  Employee USG Transfers

[ ]  Other (Please Describe: \_\_\_\_\_\_\_)

## Type of Request (To be completed by institution)

[ ]  Medical Benefit Request?

[ ]  Provider Plan Name:

[ ]  EE Amount: [ ]  ER Amount:

[ ]  Voluntary Benefit Request?

[ ]  Provider Plan Name:

[ ]  Provider Plan Name:

[ ]  Provider Plan Name:

[ ]  Provider Plan Name:

## Supporting Materials for Request

Please insert screen prints or other items to support request.

## Verification (To be completed by Alight)

Date request was received by Alight:

Alight research and/or confirmation on request (Please enter information in bullet format):

## USO Final Decision for Request

[ ]  Denied

[ ]  Approved

Please reason for decision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide your name, date and time as electronic signature for decision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_