# Reconciliation Escalation Form (Requests greater than 90 days)

**Send completed form to:** [**USGfinancialmanager@alight.com**](mailto: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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_