OhioDAS

Ohio Department of Administrative Services
Human Resource Division
Benefits Administration Services

DISABILITY - REQUEST FOR APPEAL

Name (Please type or print) _____ **Disability Claim Number** _____

I hereby request an appeal.

Signature _____ **Date** _____

I am submitting additional information. ❒ ***Yes*** ❒ ***No***

(If yes, please attach the information to this completed form)

Return this completed Disability - Request For Appeal form to your agency by the deadline date on the letter that accompanied this form.

Form Rev. Oct. 2007