Employee Benefits Security Administration

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Contact EBSA
Request Assistance
Solicitud de Asistencia

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Request for Assistance from The Department of Labor, EBSA

General Information | Printable Mail-In Form | Español

* Denotes required information. OMB Control Number: 1210-0146 Exp. Date: 09/30/2014

Inquirer Information

First Name:*
Last Name:*
Middle Initial:
Street Address:
City:
State/Zip:*
Best phone number to reach you during business hours:* Ext: Telephone Type
Alternate phone number: Ext: Telephone Type
Email Address:

*Note: e-mail address is not required; however if not provided the Department will not be able to contact you by e-mail.

You are a:

- ○ Participant/Beneficiary (such as Employee/Dependent)

If you are not the employee, please provide name of the employee
Name:

- ○ Plan Sponsor - Employer/Union
- ○ Plan Service Provider (such as Third Party Administrator, Accountant, Attorney, etc.)
- ○ Health Care Provider
- ○ Government Agency
- ○ Other (requires comments)

Comments:

Please check all below that apply

The Plan you are contacting us about is a:

- ☐ Health Plan (such as medical, dental, vision, etc.)
- ☐ Other Welfare Plan (such as long term/short term disability, severance, life insurance, etc.)
- ☐ Retirement/Pension (such as 401(k) plan, defined benefit plan, profit sharing plan, etc.)

You are requesting assistance with:

- ☐ Locating or contacting your plan
- ☐ COBRA Notice / COBRA benefits
- ☐ Getting documents or statements from your plan
- ☐ Getting benefit claims paid
- ☐ Notice of potential private pension from the Social Security Administration
- ☐ Eligibility for employer sponsored benefits
- ☐ Plan operation (such as funds not being deposited in the plan, employer has not paid premiums, investments, etc.)
- ☐ Employer has filed, or is about to file bankruptcy
- ☐ Employer has undergone, or is about to undergo a merger / acquisition
- ☐ Plan is not complying with legal requirements (such as ERISA, COBRA, HIPAA, the Affordable Care Act)
- ☐ General information about ERISA requirements such as health laws or pension laws
- ☐ Other - describe in other information and comments below

Employer/Plan Contact Information

Type:
Name:
Best Person to Contact
First Name:
Last Name:
Middle Initial:
Address:
Zip Code:
City:
State:
Phone Number: Ext: Telephone Type
Alternate Phone Number: Ext: Telephone Type
Email:
Website:

Add Another Plan Contact

Other Information and Comments

Please provide more detailed information about why you are contacting the Department for assistance below. Include information on efforts you have made to contact the plan administrator or employer to resolve the problem. Include a comment on how you believe your issue should be resolved and explain why. *Please attach all relevant information to the request for assistance, such as: copies of claims, copies of insurance cards or benefits statements, copies of Notices of Potential Pensions received from Social Security, copies of any responses received from your inquiries to the plan administrator, copies of relevant portions of the plan documents or SPD (summary plan description).* If your issue is related to a claim for pension benefits, please include the dates of employment and the employee's date of birth. If your issue is related to health claims, please include details on the date(s) of service and the
amount(s) of the claim(s). See below on how to attach documents.

4000 Characters Remaining

Attachments

If you have attachments you would like to append to your inquiry select the appropriate button below. If you select yes, after submitting your inquiry you will then be directed to the attachment upload page.

- Yes, I have attachments I would like to upload.
- No, I do not have any attachments.

When you have completed the form click Submit

Submit