SEBB Employee Request for Review/Notice of Appeal

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Type or print clearly in dark ink and use all capital, block lettering in the spaces provided. Example: J O H N.
Keep a copy of your form for your records.

Use this appeal form if you are a current or former employee (or their dependent). Follow the instructions under the heading that describes your situation.

If you disagree with **a decision made by the employer** and you are requesting the employer's review about premium surcharges or eligibility for or enrollment in:

- A premium payment plan
- Medical coverage
- Dental coverage
- Vision coverage
- Life insurance
- Accidental death and dismemberment (AD&D) insurance
- Long-term disability (LTD) insurance
- Medical Flexible Spending Arrangement (FSA) or Limited Purpose FSA
- Dependent Care Assistance Program (DCAP)

Complete Sections 1 through 3 of this form and submit it to the employer's payroll or benefits office.

The employer must receive this form **no later than 30 calendar days** after the date on the denial notice regarding the decision you are appealing.

If you disagree with **a review decision made by the employer** and you are requesting a SEBB Appeals Unit review of the employer's decision

Complete Section 7, sign and date Section 9 of this form, and submit it to the SEBB Appeals Unit.

The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's written review decision date in Section 4.

If you disagree with a **decision from the SEBB Program** about:

- Eligibility for or enrollment in:
  - A premium payment plan
  - Medical Flexible Spending Arrangement (FSA) or Limited Purpose FSA
  - Dependent Care Assistance Program (DCAP)
  - Life insurance
  - AD&D insurance
  - LTD insurance
- Eligibility to participate in SmartHealth or receive a wellness incentive
- Eligibility and enrollment for a dependent, extended dependent, or dependent child with a disability
- Premium surcharges
- Premium payments

Do not use this form.
Follow the appeal instructions on the decision letter you received from the SEBB Program.

If you disagree with **a decision made by a SEBB medical, dental, or vision plan or contracted vendor** about:

- A benefit or claim
- Completion of SmartHealth requirements or a request for a reasonable alternative to a SmartHealth requirement
- Life insurance and AD&D insurance premium payments

Do not use this form.
Contact the medical, dental, or vision plan or contracted vendor to request information on how to appeal the decision.

Request for initial employer review

Employees, former employees, or dependents may appeal. Your appeal must comply with all deadlines on page 1.

1 Appellant information

To be completed by the person filing the request for review or appeal (the appellant).

Select one:

- Employee or former employee
- Dependent of employee or former employee
- Applicant (not currently enrolled in SEBB benefits)

SEBB organization

Social Security number Date of birth

Last name

First name Middle initial

Street address

Address line 2

City State

ZIP/Postal code

Mailing address (if different)

Address line 2

City State

ZIP/Postal code

Phone number Alternate phone number

Email address

Appellant's last name

Social Security number

Other enrollee information (if appeal concerns people other than the appellant)

Enrollee 1

Last name

First name

Middle initial

Social Security number

Enrollee 2

Last name

First name

Middle initial

Social Security number

2 Describe your request for review or appeal

Describe the situation that led to your appeal and what you are asking for. Please be as detailed as possible. You may attach additional pages as needed.

3 Appellant signature

Sign and date this section. Keep a copy of this form for your records. Submit the signed request to the SEBB organization for review, if applicable.

By submitting this form, I declare that the information I have provided is true, complete, and correct.

Appellant's signature

Date

Appellant's last name

Social Security number

4 Employer response to appellant request for review

Instructions for employer

Complete Sections 4 through 6 (as applicable) to provide the requested review of your decision about the employee's or dependent's eligibility for benefits, enrollment, or a premium surcharge.

1. Complete Section 4 and Section 6 after the appellant completes Sections 1 through 3; see WAC 182-32-2020 for guidance.
2. **In addition, complete Section 5 if you agree that a wrong decision or action occurred**.
   - If correcting an enrollment error as described in WAC 182-30-060 and SEBB Program Administrative Policy 11-3, forward your recommendation for correction of the enrollment error to the SEBB Program Outreach and Training Unit for final approval by secure message through the HCA Support portal at **support.hca.wa.gov**. You must set up a secure login for this option.
   - For life, AD&D, or LTD insurance eligibility, enrollment, or premium issues, forward your recommendation to correct the decision or action caused by delay or error by secure message to the SEBB Program Outreach and Training Unit for a final approval.
3. Section 6 must be completed by a staff person who **did not** participate in the initial denial or decision-making process.
4. After completing all required sections:
   - Return this form to the appellant within **30 calendar days** of receipt.
   - Provide a copy to the employer's administrator (or designee).

If the employer does not make a decision within 30 days, the appellant may contact the SEBB Appeals Unit.

To be completed by the employer

SEBB organization

School

Organization contact last name

Contact first name

Contact phone number

Contact email address

Date you received the appellant's completed and signed request for review

Full name and job title of the person who made this initial denial or decision on the appellant's request for review.

Last name

First name

Job title

Subscriber's last name

Social Security number

List the SEBB Program rule(s) the denial or decision was based on, if known:

Date of employer's review decision on employee request for review. The SEBB Appeals Unit must receive the next level of appeal **no later than 30 days** after this date. If the SEBB Appeals Unit receives your appeal by the deadline, it will be considered timely.

Employer must check only one box

- The employer stands by the denial. The appellant has the right to appeal this decision by completing Section 7. The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the date of the SEBB organization's review decision noted above.
- The employer believes that a wrong decision or action occurred and must complete Section 5.

If the appeal relates to a decision made by the SEBB Program, the appellant is responsible for complying with the timelines described on the decision letter. Please note that this appeal form does not need to be used if the SEBB Program has already sent a decision letter.

5 Employer response (if applicable)

To be completed by the employer only when the employer agrees a wrong decision or action occurred.
Why do you believe a wrong decision or action occurred?

- SEBB organization delay
- SEBB organization error

Please explain the delay or error:

What do you recommend to correct the decision or action?

Subscriber’s last name

Social Security number

6 Employer signature

To be completed by a reviewer who did not participate in the initial denial or decision-making process under appeal, such as the employer's administrator or a designee. Complete this section after the employer completes Section 4 (and Section 5, if applicable).

Reviewer’s last name

First name

Phone number

Reviewer’s signature

Date

7 Employee notice of appeal to the SEBB Appeals Unit

To be completed by the appellant. Your appeal must comply with all applicable deadlines on page 1.

Instructions for appellant:

- Do not complete this section until you receive a completed copy of this form from the employer, unless you are directly appealing a decision made by the SEBB Program.
- If you wish to appeal the employer's decision, or you agree with the employer that a wrong decision or action occurred, complete this section, sign and date Section 9, and submit this form to the SEBB Appeals Unit as instructed below.
- You may attach a statement that identifies the specific portion of the decision you are appealing and explains why you agree or disagree with the employer's decision, and submit additional documentation for review.
- The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's review decision date in Section 4.
- If the employer does not make a decision within 30 days, the appellant may contact the SEBB Appeals Unit.

Response to the employer's reason for denial listed in Section 4, if applicable.

Additional information you want the SEBB Appeals Unit to consider that was not mentioned before.

Are you attaching additional documentation?

No.

Yes. I have attached additional documents, such as forms or correspondence between the employer or the SEBB Program and me. (Please identify the document and the reason you are submitting it.)

Subscriber's last name

Social Security number

8 Representative information (if applicable)

If you have someone representing you, you must submit the *Authorization for Release of Information* form available on the SEBB Appeals webpage at **hca.wa.gov/sebb-appeals.** Or, you may submit a power of attorney document. Please call the SEBB Appeals Unit for more information at 1-800-351-6827.

Representative's last name

First name

Middle initial

Mailing address

Address line 2

City

State

ZIP/Postal code

Phone number

Alternate phone number

Email address

Relationship to appellant

Washington State Bar Association number (if applicable)

9 Appellant signature and electronic service option

Sign and date this section. Keep a copy of this form for your records.

Electronic service

By signing and providing my email address below, I agree to receive service of appeal documents and orders from the SEBB Appeals Unit by secure message. I understand that the SEBB Appeals Unit will use secure messages to serve documents and orders on me at the email address below. I understand that service is complete when the SEBB Appeals Unit sends the email, not when I view it. (Please print clearly.)

Email address

By signing this form, I declare that the information I have provided is true, complete, and correct.

Appellant's signature

Date

How to submit this form

The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the EBB Organization's review decision date in Section 4 to request a brief adjudicative proceeding. Submit this form by mail or fax.

Mail
Health Care Authority
SEBB Appeals Unit
PO Box 45504
Olympia, WA 98504

Fax
360-763-4709