HCA | Health Care Authority
Public Employees Benefits Board

PEBB Retiree/Continuation Coverage Notice of Appeal

Complete this form to request a brief adjudicative proceeding and submit it to the PEBB Appeals Unit as instructed on the last page of this form. The PEBB Appeals Unit must receive this form **no later than 60 days** after the date of the PEBB Program denial or decision letter you received. Your appeal may concern:

- Eligibility for benefits
- Enrollment
- Premium payments
- Premium surcharges
- Eligibility to participate in SmartHealth or receive a wellness incentive

⚠ If you are seeking a review of a decision by a PEBB medical, dental, or vision plan, insurance carrier, or benefit administrator, do not use this form. Contact the medical, dental, or vision plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.

Type or print clearly in dark ink and use all capital, block lettering in the spaces provided.
Example: J O H N

1 Appellant information

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

Select one:

- ☐ PEBB retiree subscriber
- ☐ Applicant (not currently enrolled in PEBB coverage)
- ☐ Surviving dependent
- ☐ Dependent of a PEBB retiree or PEBB Continuation Coverage subscriber
- ☐ PEBB Continuation Coverage subscriber

Social Security number

Last name

First name

Middle initial

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

Appellant's last name

Last four digits of Social Security number

Mailing address (if different)

Address line 2

City

State

ZIP/Postal code

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

Enrollee 1

Last name

Middle initial

First name

Enrollee 2

Last name

Middle initial

First name

Enrollee 3

Last name

Middle initial

First name

2 Describe your request for appeal

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

Appellant's last name

Last four digits of Social Security number

Are you attaching additional information?

☐ No.

☐ Yes. I have attached additional documents, such as forms or correspondence between the PEBB Program and me or my representative.

Please identify the documents and the reason you are submitting them.

3 Representative information

If you have someone representing you, you must also complete the *Authorization for Release of Information* available on the PEBB Appeals webpage at **hca.wa.gov/pebb-appeals**. Or, you may submit a power of attorney document. If you have questions, call the PEBB Appeals Unit at 1-800-351-6827.

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)

Appellant's last name

Last four digits of Social Security number

4 Appellant signature and electronic service option

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

By signing and providing my email address below, I agree to receive service of appeal documents and orders from the PEBB Appeals Unit by secure message. I understand that the PEBB 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 PEBB Appeals Unit sends the email, not when I view it. (Please print clearly.)

Email address

☐ I do not wish to use the electronic service. I understand that by selecting this box, I will not receive appeal-related correspondence via email and will instead receive items related to my appeal via U.S. mail.

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 PEBB Appeals Unit must receive this form **no later than 60 days** after the date on the PEBB Program denial or decision letter to request a brief adjudicative proceeding. Submit this form by mail or fax.

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

Fax
360-763-4709