# SEBB Employee Request for Review/Notice of Appeal

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

- Type or print clearly in dark ink. Example: J O H N
- Keep a copy of this completed form for your

| If your situation is | Follow these instructions and submission deadlines |
|---|---|
| You are a **current or former employee** (or their dependent) and you disagree with **a decision made by your employer** and you are requesting your employer's review about your premium surcharges or eligibility for or enrollment in:<br>• Premium payment plan<br>• Medical coverage<br>• Dental coverage<br>• Vision coverage<br>• Life insurance<br>• Accidental death and dismemberment (AD&D) insurance<br>• Long-term disability (LTD) insurance<br>• Medical Flexible Spending Arrangement (FSA)<br>• Dependent Care Assistance Program (DCAP) | Complete Sections 1 through 3 of this form and **submit it to your employer's payroll or benefits office.**<br><br>**Deadline**: Your employer must receive this form **no later than 30 calendar days** after the date on the denial notice regarding the decision you are appealing. |
| You are a current or former employee (or their dependent) and you disagree with a review decision **made by the employer**, or agree further review is needed because the employer believes there was an error but did not grant you the relief you requested. You are now **requesting the 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.<br><br>**Deadline:** 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. |
| You are a current or former employee (or their dependent) and your appeal concerns **a decision from the SEBB Program** about:<br>• Eligibility for or enrollment in:<br>  • Premium payment plan<br>  • Medical Flexible Spending Arrangement (FSA)<br>  • Dependent Care Assistance Program (DCAP)<br>  • Life insurance<br>  • AD&D insurance<br>  • LTD insurance<br>• Eligibility to participate in SmartHealth or receive a wellness incentive<br>• Eligibility and enrollment for a dependent, extended dependent, or dependent child with a disability<br>• Premium surcharges<br>• Premium payments | **Do not use this form.**<br>Follow the appeal instructions on the decision letter you received from the SEBB Program. |
| You are a current or former employee (or their dependent) and you are seeking review of **a decision made by a SEBB medical, dental, or vision plan or contracted vendor** about:<br>• A benefit or claim<br>• Completion of SmartHealth requirements or a request for a reasonable alternative to a SmartHealth requirement<br>• Life insurance and AD&D insurance premium payments | **Do not use this form.**<br>Contact the medical, dental, or vision plan or contracted vendor to request information on how to appeal the decision. |

## Employee request for review (initial employer review)

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
- Applicant (not currently enrolled in a SEBB benefit)
- Dependent of employee or former employee

SEBB organization (employer)

Social Security number

Last name

First name | Middle initial

Phone number | Alternate phone number

Email address

Street address

Street address line 2

City | State

ZIP/Postal code

Mailing address (if differentl)

Mailing address line 2

City | State

ZIP/Postal Code

Appellant's last name | First name | Middle initial

## 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

**Enrollee 3**
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 signed request to your employer for review, if applicable.

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

Signature | Date

Appellant's last name | First name | Middle initial

## 4 Employer response to appellant's request for review

### Instructions for employers

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**.
   a. 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 by FUZE secure email to the SEBB Program for final determination.
   b. 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 FUZE secure email to the SEBB Program for final determination. Send a secure online message from the FUZE webpage at **hca.wa.gov/fuze-questions**. You must set up a secure login for this feature.
3. Section 6 must be signed by a staff person who **did not** participate in the initial denial or decision-making process.
4. After completing all required sections:
   a. Return this form to the appellant **within 30 calendar days** of receipt.
   b. Provide a copy to your SEBB organization (or designee) and the SEBB Appeals Unit for their records.

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 (employer)

School

Organization contact last name

Contact first name | Contact's phone number

Contact's 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

Title

Appellant's last name | First name | Middle initial

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

Date of employer's review decision on *Employee's request for review*. The next level of appeal must be received by the SEBB Appeals Unit **no later than 30 days after this date.**

If the SEBB Appeals Unit receives your appeal by the deadline, it will be considered timely.
**Select one** (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 employer's review decision noted above.
- The employer believes that a wrong decision or action occurred, and must complete Section 5.

If this appeal relates to a decision made by the SEBB Program, the appellant is responsible for complying with the timelines described on 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 if 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?**

## 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 (print or type)

First name | Phone number

Reviewer's signature | Date

Appellant's last name | First name | Middle initial

## 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 your 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.

**Response to your 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 my employer or the SEBB Program and me. Please identify the document and the reason you are submitting it.

Appellant's last name | First name | Middle initial

## 8 Representative information (if applicable)

If you have someone representing you, you must complete HCA's *Authorization for Release of Information* form on the HCA website at **hca.wa.gov/health-care-services-supports** under Forms & publications (please submit this completed form with the appeal). Or, you may submit a power of attorney (POA) document (please note additional documentation may be requested if a POA is submitted). Please contact the SEBB Appeals Unit for additional information at 1-800-351-6827.

Last name

First name | Middle initial

Phone number | Alternate phone number

Email address

Relationship to appellant | Washington State Bar Association number (If applicable)

Mailing address

Mailing address line 2

City | State | ZIP/Postal code

## 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 email. I understand that service is complete when the email is sent to the correct email address I have listed below, not when I view the email. I understand that the SEBB Appeals Unit will use a secure email platform to serve documents and orders on me at this email address: (Please print clearly.)

This appeal form must be faxed or mailed to the SEBB Appeals Unit at the contact information listed below.

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

Signature | Date

### How to submit this form

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

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

**Fax**
360-763-4709