SEBB Continuation Coverage 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. The SEBB Appeals Unit must receive this form **no later than 60 calendar days** after the date of the denial notice regarding the decision you are appealing.

Instructions and deadlines

Use this appeal form if you are an applicant for SEBB insurance coverage, a SEBB Continuation Coverage subscriber, or their dependent. Follow the instructions under the heading that describes your situation.

If your appeal concerns a decision from the SEBB Program about:

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

Complete this form to request a brief adjudicative proceeding and submit it to the SEBB Appeals Unit as instructed on the last page of this form.

The SEBB Appeals Unit must receive the form **no later than 60 calendar days** after the date of the denial notice regarding the decision you are appealing.

If you are seeking a review of a decision by a SEBB medical, dental, or vision plan, insurance carrier, or benefit administrator about:

- A benefit or claim
- Completion of the SmartHealth requirements or a reasonable alternative request

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.

1 Appellant information

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

- ☐ SEBB Continuation Coverage subscriber (including termination of coverage)
- ☐ Applicant (not currently enrolled in SEBB Continuation Coverage)
- ☐ Dependent of a SEBB Continuation Coverage subscriber

Social Security number

Last name

First name

Middle initial

Phone number

Alternate phone number

Email address

SEBB Continuation Coverage Notice of Appeal

Appellant's last name

Social Security number

Street address

Address line 2

City

State

ZIP/Postal code

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP/Postal code

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

Appellant's last name

Social Security number

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.

Are you attaching additional documentation?

☐ No.

☐ Yes. I have attached additional documents, such as forms or correspondence between the SEBB Program and me or my representative.
(Please identify the documents and the reason you are submitting them.)

These documents show:

3 Representative information

If you have someone representing you, you must submit the *Authorization for Release of Information* available on 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)

Appellant's last name

Social Security number

4 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.)

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 60 calendar days** after the date on the SEBB Program decision letter 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