Washington State Health Care Authority
School Employees Benefits Board
P.O. Box 42720 • Olympia, Washington 98504-2720
www.hca.wa.gov/sebb

Name
Address
City State ZIP

<Date>

Your dependent(s) will not be enrolled in SEBB health plan coverage

Dear Subscriber:

You chose to enroll dependent(s) under your School Employees Benefits Board (SEBB) health plan coverage effective January 1, 2020.

However, we did not receive the valid proof of eligibility necessary to enroll the dependent(s) or the dependent does not meet SEBB eligibility rules as defined in WAC 182-31-140. This means that **the person(s) listed below** are not eligible for SEBB health plan coverage as dependents; they will not be enrolled under your coverage starting January 1, 2020.

Name 1
Name 2
Name 3
Name 4
Name 5
Name 6
Name 7
Name 8
Name 9
Name 10
Name 11
Name 12
Name 13
Name 14
Name 15

A list of acceptable dependent verification documents can be found at **hca.wa.gov/sebb-employee** under *Eligibility & enrollment*, or in the enrollment guide.

If you requested to enroll other dependents who are not listed in this letter, you may receive separate notification(s) from the SEBB Program regarding their eligibility for SEBB health plan coverage.

What other health coverage is available?

Coverage may be available through the Health Insurance Marketplace. For Washington State residents, visit **wahealthplanfinder.org** or call 1-855-923-4633. Outside Washington State, visit **healthcare.gov** or call 1-800-318-2596.

What if I disagree with this decision?

If you disagree with this decision, you may file an appeal. If you choose to appeal, the SEBB Appeals Unit must receive your appeal in writing **no later than 30 calendar days** after the date of this letter. You should submit any supporting documentation with your appeal including any valid dependent verification.

You can find more information about how to submit an appeal on the next page and at **hca.wa.gov/sebb-appeals**.

If you have questions about this letter, including why your proof of eligibility was denied, please contact your payroll or benefits office.

Sincerely,

SEBB Program

How to submit a SEBB appeal

Write a letter to the SEBB Program stating you disagree with this decision and would like to file an appeal.

Make sure you submit your appeal so the SEBB Appeals Unit receives it **no later than 30 calendar days** after the date of this letter.

Your appeal should contain:

1. Your name and mailing address.
2. The name and mailing address of your representative, if any.
3. Documentation or reference to documentation of decisions previously provided through the appeal process, if any.
4. A statement identifying the specific portion of the decision you are appealing and clarifying what you believe to be unlawful or in error.
5. A statement of facts in support of your position.
6. Any information or documentation you would like considered that supports why the decision should be reversed. Information or documentation submitted later, unless specifically requested by the SEBB Appeals Unit, may not be considered in the appeal decision.
7. The type of relief you are seeking.
8. A statement that says you have read the notice of appeal and believe the contents to be true and correct.
9. Your signature or your representative's signature.

Submit your appeal by one of the following methods:

Fax: 360-586-9080

Mail: Health Care Authority
SEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Hand deliver: Health Care Authority
626 8th Avenue SE
Olympia, WA 98501