Health Care Authority
Public Employees Benefits Board

PEBB Long-Term Disability (LTD) Insurance Correction Form

Employers: Use this form to correct keying errors for an LTD insurance form originally signed and submitted by an employee.

Instructions

To process employee-paid LTD keying errors:

- The employer completes this form, provides a copy to the employee, and keeps a copy (with supporting documentation) for their records.
- The employer must keep paper or electronic files that support the decision made and the action taken on any error corrections, even if a change was not made.
- The employee must agree to the change by signing this form.
    - If the corrected error results in a **higher** coverage amount, the employee must pay the difference in premiums for the most recent 24 months of coverage (WAC 182-08-187 (4)(b)(i)). The employer is responsible for additional months of premiums.
    - If the corrected error results in a **lower** coverage amount (including no coverage), the employer (in coordination with Standard Insurance Company) will refund overpaid premiums to the employee (WAC 182-08-187 (4)(b)(ii)).
- The employer corrects the error back to the effective date of the error.

Appeal rights

An employee who does not agree with a decision made by their employer or the PEBB Program may appeal the decision by submitting an appeal **within 30 days** (Chapter 182-16 WAC).

1 Employee information

Social Security number

Last name

Middle initial

First name

Employer name

Employer agency/subagency code

2 Correction needed

What LTD insurance error needs correcting?

- ☐ Employee-paid coverage was reduced, but not keyed.
- ☐ Employee-paid LTD coverage was declined by employee, but not keyed.
- ☐ Employee-paid coverage was elected by employee, but not keyed.
- ☐ Employee's salary was keyed incorrectly.
- ☐ Coverage level for employee-paid LTD coverage was keyed incorrectly.
- ☐ Other:

Date of keying error

Date coverage was corrected

Premium adjustment (select one)

- ☐ Correction resulted in a **higher** coverage amount. Employee agrees to pay $ in back premiums from through .
- ☐ Correction resulted in a **lower** coverage amount. Employee will be refunded $ for premiums from through .
- ☐ Other:

3 Signatures

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

Employer representative's printed name

Employer representative's signature

Date

Employee's signature

Date