INSERT AGENCY LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE NAME,

During a review of your eligibility for PEBB Program insurance, we discovered that we notified you of your eligibility for benefits on MM/DD/YYYY and received your Employee Enrollment forms timely. We failed to enroll you in PEBB insurance coverage as elected (WAC 182-08-187). In order to correct this enrollment failure, we will enroll your PEBB Program health insurance to be effective the first of the month following the date of this notice.

**Medical and Dental Insurance:** The effective date for your PEBB Program health insurance is MM/DD/YYYY.

However, you have the option to request retroactive enrollment as allowable under the recourse options outlined below. If you request retroactive enrollment, you will not be responsible for premiums for any months prior to this notification (WAC 182-08-187(3)(a)).

**Life Insurance and Long-Term Disability Insurance: :** The *MetLife Enrollment/Change* form and *Long-Term Disability Enrollment/Change* form must be received by this office no later than 31 days after the date of this notification. You will automatically be enrolled in employer-paid basic life and LTD insurance effective retroactive to the original effective date of MM/DD/YYYY.

If you choose to enroll in optional life insurance you will be notified by MetLife of the effective date for coverage not requiring statement of health. Our agency has sent the Notification of Employment Status Changes form to MetLife to notify them of our late notification.

If you choose to enroll in optional long-term disability, the coverage will be effective the first day of the month following your original date of eligibility provided back premiums are paid. A separate form will be provided for the long-term disability insurance correction with the amount of back premiums owed.

**Recourse options** may be considered for medical and dental for the time period of \* MM/DD/YYYY to MM/DD/YYYY.

When correcting enrollment errors, the employer must work with the employee and the Health Care  Authority to implement insurance coverage within the following parameters:

* Retroactive enrollment in a PEBB Program health plan;
* Reimbursement of claims paid;
* Reimbursement of amounts paid for medical and dental premiums; or
* Other recourse, upon approval by the Health Care Authority

**Recourse** must not contradict a specific provision of federal law or statute and does not apply to requests for non-covered services or in the case of an individual who is not eligible for PEBB Program benefits.

**An employee** who does not agree with a recourse decision of the employing agency or the Health Care Authority may appeal the decision by submitting an appeal within 30 days as outlined in WAC 182-16.

**Failure to respond** within 31 days of the date of this notice, will result in enrollment as described in WAC 182-08-197(1)(b) with no option for recourse. The effective date of coverage will be prospective from the date of notification as described above.

 Continued …

**Please select the response(s) below; sign, date and return the letter confirming your request:**

[ ]  I agree to prospective enrollment in PEBB Program health insurance coverage effective MM/DD/YYYY.

[ ]  I agree to retroactive enrollment in PEBB Program health insurance coverage with an effective date of \*\_\_\_\_\_\_\_\_\_\_\_\_. I understand my employer will pay for my employee premiums due from MM/DD/YYYY to MM/DD/YYYY. I will be responsible for medical premiums effectiveMM/DD/YYYY.

**Recourse Options**

[ ]  I do not choose to pursue any recourse.

[ ]  I choose to pursue the following recourse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Employee Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sincerely,

AGENCY SIGNATURE

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