INSERT AGENCY LETTERHEAD

MM/DD/YYYY

Dear NAME,

During a retrospective review of your eligibility for PEBB Program insurance we discovered that we notified you of your eligibility for benefits MM/DD/YYYY. However, we did not receive your enrollment forms within the deadline outlined in the notification and as a result, there was a failure to enroll you as required (WAC 182-08-187).

When forms are not received or are received late, PEBB Program rules require enrollment in the following default plans, Uniform Medical Plan Classic, Uniform Dental Plan, basic life insurance, basic long-term disability insurance as a single subscriber (dependents will not be enrolled). In addition, you are subject to the tobacco use premium surcharge (WAC 182-08-197(1)(b)).

**Medical and Dental Insurance:** As required by PEBB Program rules, you will be enrolled as a single subscriber in the Uniform Medical Plan Classic and the Uniform Dental Plan effective 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.

**Life Insurance and Long-Term Disability Insurance:** You will be enrolled in employer-paid basic life insurance and basic long-term disability insurance effective retroactive to the original effective date. If you choose to request supplemental life insurance and/or optional long-term disability insurance, evidence of insurability will be required.

**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 to this notice** 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 default enrollment effective MM/DD/YYYY. I understand I will be enrolled, as a single subscriber, in Uniform Medical Plan Classic, the Uniform Dental Plan and subject to the tobacco use premium surcharge. (WAC 182-08-197(1)(b)).

[ ]  I agree to retroactive default enrollment in PEBB Program health insurance coverage effective \*\_\_\_\_\_\_\_\_\_\_\_\_. I understand I will be enrolled, as a single subscriber, in Uniform Medical Plan Classic, the Uniform Dental Plan and subject to the tobacco use premium surcharge (WAC 182-08-197(1)(b)). 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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