INSERT AGENCY LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE NAME,

During a retrospective review of eligibility for your PEBB Program insurance it was discovered that you became eligible to apply for PEBB Program benefits onMM/DD/YYYY and we failed to notify you of your eligibility timely (WAC 182-45-114). In order to correct the error, we are providing written notification of your eligibility and offering you a new enrollment period. (WAC 182-08-187).

**Medical and Dental insurance:** The *Employee Enrollment/Change* form must be received by this office no later than 31 days after the date of this notification. Failure to return the form within 31 days will result in automatic default enrollment in Uniform Medical Plan Classic and Uniform Dental Plan as a single subscriber (no dependents enrolled). In addition you will be subject to the tobacco use premium surcharge (WAC 182-08-197(1)(b)).

Your effective date of coverage 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.

**Life 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 this notice will result in default 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 appropriate response(s) below; sign, date and return the letter confirming your enrollment 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,

INSERT AGENCY SIGNATURE