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 MM/DD/YYYY. Your enrollment forms were not received within the deadline outlined in the eligibility notification and as a result, there was a failure to enroll you as required (WAC 182-08-187). In order to correct this error, we will enroll you effective the first of the month following the date of this notice.

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 and 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:** Your Medical and Dental insurance coverage is effective MM/DD/YYYY. However, you have the option to request retroactive enrollment as allowable under the recourse options outlined below.

**Life Insurance and Long-Term Disability (LTD) 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 request supplemental life insurance and/or supplemental 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 within 31 days** will result in enrollment, as described, forfeiting the request for recourse.

**Please complete** the enrollment request, found on the next page, and return to the address provided.

Sincerely,

AGENCY SIGNATURE

BLOCK

MM/DD/YYYY

**Please confirm the enrollment/recourse request, sign, date, and return the document within 31 days of this notice:**

I understand that by failing to submit completed enrollment forms within the allowed deadlines, I will be enrolled in default coverage, as described in WAC 182-08-197(1)(b).

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

[ ]  I agree to retroactive enrollment in default PEBB Program health insurance coverage effective back to \*\_\_\_\_\_\_\_\_\_\_.

 (\***Employee to choose the start date** of coverage between MM/DD/YYYY and MM/DD/YYYY)

[ ]  I request the following recourse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Return document the following address:

INSERT RETURN ADDRESS