INSERT AGENCY LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE NAME,

During a 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 182-12-114).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). Your PEBB coverage is effective the first of the month, following the date of this notice.

**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)).

**Medical and Dental insurance: The effective date of your 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 the eligible month(s), up to and including the month of this notification: MM/DD/YYYY to MM/DD/YYYY. You will be responsible for employee premiums, the first of the month following this notice.

**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.

**Supplemental 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.

**Supplemental long-term disability (LTD),** 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.

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

Sincerely,

AGENCY SIGNATURE

BLOCK

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MM/DD/YYYY

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

I request to enroll in PEBB Program benefits, per elections made on the completed Employee Enrollment form submitted to my employer:

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

I request enrollment in PEBB Program health insurance coverage to be effective back to \*\_\_\_\_\_\_\_\_\_\_.

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

I understand I am responsible for employee premiums starting the first of the month following the date of this notice.

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

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

Return document the following address:

INSERT RETURN ADDRESS

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