INSERT SCHOOL DISTRICT LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE NAME:

During a review of eligibility for your SEBB program insurance, it was discovered that you became eligible to apply for benefits onMM/DD/YYYY and we failed to notify you of your eligibility within a reasonable timeframe (WAC 182-31-030(2)(e). To correct the notification error, we are providing written notification of your eligibility and offering you a new enrollment period (WAC 182-30-060). Your SEBB program benefits will begin prospective, the first day of the month following the date of this notice.

**SEBB PROGRAM INSURANCE:** The *Employee Enrollment/Change* form must be received by this office no later than 31 days after the date of this notification (WAC 182-30-080). Failure to return the form within 31 days will result in automatic default enrollment in Uniform Medical Plan Achieve 1, Uniform Dental Plan, MetLife Vision insurance, Basic Life insurance, Basic Accidental Death, and Dismemberment (AD&D) insurance, employer-paid, and employee-paid Long-term Disability (LTD) insurance, your dependents will not be enrolled, and you will incur a monthly tobacco use premium surcharge (WAC 182-30-080(1)(b)).

**Medical, Dental and Vision 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. You will be responsible for employee premiums the first of the month following this notice.

**Recourse options** may be considered for medical, dental and vision for the 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 SEBB Program health plan
* Reimbursement of claims paid
* Reimbursement of amounts paid for medical, dental and vision 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 SEBB 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 182-16-2010.

**Failure to respond** within 31 days of this notice will result in default enrollment and 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,

EMPLOYER SIGNATURE BLOCK

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 SEBB Program benefits, per my elections made on the completed Employee Enrollment form(s)

submitted to my employer:

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

[ ]  I request to retroactive enrollment in SEBB Program health insurance coverage with an effective date of \*\_\_\_\_\_\_\_\_\_\_.

 (\***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 to the following address:

INSERT RETURN ADDRESS