Month Day, Year

Dear Employee Name,

During a review of your School Employee Benefits (SEBB) Program insurance, we verified that you became eligible to apply for benefits on MM/DD/YYYY and we notified you of your eligibility (WAC 182-31-030 (2)(e)). However, we did not receive your enrollment forms/elections within the deadline (outlined in the eligibility notification) and as a result, there was a failure to enroll you as required.

To correct this error, you will be enrolled in default benefits the first of the month following the date on this notification. **Your effective date of coverage** is MM/DD/YYYY.

When forms are not received or are received late, SEBB Program rules **require** enrollment as single subscriber in the following default plans (WAC 182-30-080 (1)(b)):

* Uniform Medical Plan Achieve 1, Uniform Dental Plan, MetLife Vision;
* Basic Life insurance, Basic Accidental Death, and Dismemberment (AD&D) insurance;
* Employer-paid Long-term Disability (LTD) insurance and employee-paid Long-term Disability (LTD) insurance;
* Dependents will not be enrolled; and
* A monthly tobacco use premium surcharge will be incurred

**Recourse options:** Recourse may be considered for SEBB program insurance for the period of MM/DD/YYYY to MM/DD/YYYY. This means you can elect the start date of coverage for the SEBB default benefits. When correcting enrollment errors, the employer must work with the employee and the Health Care Authority to implement insurance coverage within the parameters of WAC 182-30-060 (5)(a).

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 SEBB organization or the Health Care Authority may appeal the decision by submitting an appeal within 30 days as outlined in WAC 182-32-2020.

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 both pages to the address provided.

Sincerely,

AGENCY SIGNATURE BLOCK

Month Day, Year

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

[ ]  I agree to prospective default enrollment in SEBB Program benefits to be effective MM/DD/YYYY.
 *\*I understand that I will be responsible for applicable premiums starting from the date selected above.*
[ ]  I request retroactive enrollment in default SEBB Program health insurance coverage to be effective \*\_\_\_\_\_\_\_\_\_\_\_\_.

 (\***Employee to choose the start date** of coverage between MM/DD/YYYY and MM/DD/YYYY)
 *\*I understand that I will be responsible for applicable premiums starting from the date selected above.*

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

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

Return document to the following address:

INSERT RETURN ADDRESS