Month Day, Year

Dear Employee Name,

During a review of eligibility for your School Employee Benefits (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 error, we are providing written notification of your eligibility and offering you a new enrollment period (WAC 182-30-060). Your SEBB coverage will begin the first of the month following the date of this notice.

A completed Employee Enrollment/Changeform, a Long-Term Disability (LTD) Insurance Enrollment Change form and any applicable dependent verification documents must be received by this office no later than 31 days from the date of this notice (WAC 182-30-080). Failure to return the form(s) within 31 days will result in automatic default enrollment in 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 60% employee-paid LTD, your dependents will not be enrolled, and you will incur a monthly tobacco use premium surcharge (WAC 182-30-080 (1)(b)).

**Medical, Dental, Vision:** The effective date for the corrected SEBB Program health insurance 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. However, you will be responsible for employee premiums the first day of the month following this notice.

**Employee-Paid Long-Term Disability (LTD) Insurance:** Enrollment in Employee-paid LTD insurance on any date other than your original eligibility/effective date requires submission of Evidence of Insurability (EOI) to The Standard. Submission of EOI does not guarantee enrollment; approval by The Standard is required for coverage effective dates other than MM/DD/YYYY. If retroactive enrollment is approved, you (the Employee) will be responsible for paying LTD premiums for the initial 24 months of coverage. After 24 months, premium payments become the responsibility of the Employer, as outlined in WAC 182-30-060 (4)(b)(i).

**Recourse options:** Recourse may be considered for medical, dental, and vision insurance 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 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 request to enroll in SEBB Program benefits, per my elections made on the completed Employee Enrollment form and Long Term Disability form submitted to my employer:

[ ]  I agree to prospective enrollment in SEBB Program health insurance coverage effective MM/DD/YYYY.
*\*I understand that I will be responsible for applicable premiums starting from the date selected above.**\* I understand that I will be required to send in the attached Evidence of Insurability to The Standard in
 order to gain approval for enrollment in employee paid Long Term Disability.*

[ ]  I request retroactive enrollment in 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 the first of the month following the date of
 this notice.* *\* I understand that I will be required to send in the attached Evidence of Insurability to The Standard in
 order to gain approval for enrollment in employee paid Long Term Disability if I choose any date other than
 the original date of eligibility/effective date of MM/DD/YYYY.*

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

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

Return document to the following address:

INSERT RETURN ADDRESS