INSERT SCHOOL DISTRICT LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE NAME,

During a review of eligibility for your SEBB program insurance, we verified you became eligible to apply for benefits onMM/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.

In order to correct the 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 (WAC 182-30-080(1)(b)) require enrollment in the following default plans:

* Uniform Medical Plan (UMP) Achieve 1
* Uniform Dental Plan,
* MetLife vision insurance,
* Basic Life insurance,
* Basic Accidental Death and dismemberment (AD&D) insurance,
* Basic Long-Term Disability (LTD) insurance,
* Your dependents will not be enrolled,
* You will be charged a $25-per-account monthly tobacco use premium surcharge.

**Recourse** may be considered for SEBB program insurance for the time 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 school district 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 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 SEBB Program benefits.

**You may appeal the decision within 30 days** by submitting an appeal within 30 days, as outlined in WAC 182-32, if you do not agree with a recourse decision made by your employer or the SEBB program.

**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,

AGENCY SIGNATURE

BLOCK

MM/DD/YYYY

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

[ ]  I agree to prospective enrollment in SEBB Program benefits to be effective MM/DD/YYYY.

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

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

**Return document the following address:**

INSERT RETURN ADDRESS