INSERT AGENCY LETTERHEAD

MM/DD/YYYY

Dear NAME,

During a review of your eligibility for SEBB Program insurance, we discovered that we notified you of your eligibility for benefits on MM/DD/YYYY and received your Employee Enrollment forms timely. We failed to enroll you in SEBB insurance coverage as elected (WAC 182-30-060).

 < INSERT THE DESCRIPTION OF THE ERROR >

In order to correct this enrollment error, we will correct your enrollment in SEBB Program health insurance to be effective the first of the month following the date of this notice.

**Medical and Dental Insurance:** The effective date for the corrected SEBB Program health insurance is MM/DD/YYYY. However, you have the option to request retroactive correction/enrollment as allowable under the recourse options outlined below.

**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 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** will result in prospective correction/enrollment, as described, with no other option for recourse.

**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 agree to prospective correction/enrollment in SEBB Program health insurance coverage 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

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