INSERT SCHOOL DISTRICT LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE FULL 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). In order 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 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 enrollment form within 31 days** REQUIRES default enrollment: Uniform Medical Plan (UMP) Achieve 1 (single subscriber rate/employee premium), 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 and you will be charged a $25-per-account monthly tobacco use premium surcharge. (WAC 182-30-080(1)(b)).

**Your effective date of 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 premiums the first of the month following this notice.

**Life and Long-Term Disability Insurance:** The *MetLife Enrollment/Change* form and *Long-Term Disability Enrollment/Change* form must be received by this office no later than 31 days after the date of this notification. You will automatically be enrolled in employer-paid basic life and LTD insurance effective retroactive to the original effective date of MM/DD/YYYY.

**Supplemental life insurance** you will be notified by MetLife of the effective date for coverage not requiring statement of health. Our agency has sent the Notification of Employment Status Changes form to MetLife to notify them of our late notification.

**Supplemental long-term disability (LTD),** the coverage will be effective the first day of the month following your original date of eligibility provided back premiums are paid. A separate form will be provided for the long-term disability insurance correction with the amount of back premiums owed.

**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 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 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 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