INSERT LETTERHEAD

MM/DD/YYYY

Dear FULL NAME,

During a retrospective review of your eligibility for SEBB Program insurance, it was discovered that you became ineligible for SEBB benefits on a MM/DD/YYYY and we failed to end coverage timely. We are providing you with this notification because we are unable to terminate your medical coverage retroactively, back to MM/DD/YYYY due to Federal termination rescission laws (Policy 19-1, Addendum 19-1A).

As a result, you will remain enrolled in the current medical plan from MM/DD/YYYY to MM/DD/YYYY (WAC 182-30-060). You are not responsible for the employee medical premiums during this time period and we did not collect any employee medical premiums after MM/DD/YYYY.

**Recourse options** may be considered for medical and dental for the period of MM/DD/YYYY to MM/DD/YYYY. When correcting termination 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.

**An employee** who does not agree with a recourse decision of the employing agency or the Health Care Authority may appeal the decision by submitting an appeal within 30 days as outlined in WAC 182-32.

**Failure to respond** within 31 days of this notice will result in termination, as described, without option for recourse.

**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 following information regarding your health coverage, sign and return:**

I understand my SEBB program medical and dental insurance coverage ended on MM/DD/YYYY, due to the Federal termination rescission laws and SEBB Policy 19-1A.

My employer paid the medical premiums from MM/DD/YYYY to MM/DD/YYYY and did not collect any employee medical premiums after MM/DD/YYYY. I understand am not responsible for these premiums.

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

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

**Return document to the following address:**

INSERT RETURN ADDRESS