SEBB Employee Request for Review/Notice of Appeal

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

- Type or print clearly in dark ink. Example: J O H N
- Keep a copy of this completed form for your records.

If your situation is	Follow these instructions and submission deadlines

You disagree with **a decision made by your employer and you are requesting your employer's review about:**
• Premium surcharges
• Eligibility for or enrollment in:
  • Medical coverage
  • Dental coverage
  • Vision coverage
  • Life insurance
  • Long-term disability insurance
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
	Complete Sections 1–3 of this form and **submit it to your employer's payroll or benefits office**.
	Deadline: Your employer must receive this form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

You disagree with a review decision made by your employer, or agree that further review is needed because your employer believes that there was an error but did not grant you the relief you requested, and you are now **requesting the SEBB Program's review of your employer's decision**.	**Complete** Section 7 and sign and date Section 9 of this form. **Deadline**: The SEBB Appeals Unit must **receive** this form **no later than 30 calendar days** after the date of your employer's review decision.

Your appeal concerns **a decision from the SEBB Program about**:
• Eligibility for or enrollment in:
  • Premium payment plan
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
  • Life insurance
• Eligibility to participate in SmartHealth or receive a wellness incentive
• Dependent, extended dependent, or disabled dependent eligibility
• Premium surcharges
• Premium payments
	Complete Sections 1–3 of this form.
	Check with your employer to see if they need to review this form before you submit it to the SEBB Appeals Unit (see Section 7).
	Deadline: The SEBB Appeals Unit must **receive** the form **no later than 30 calendar days** after the date of the denial notice or decision you are appealing.

You want to **review a decision by a SEBB health plan, insurance carrier, or benefits administrator about** the administration of a health plan or benefit, or a benefit or claim.	**Contact** the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision. **Do not use this form.**

Appellant's last name	First name	Middle initial

Employee request for review (initial employer review)

Note: Your appeal must comply with all deadlines on page 1.

1 Appellant information

To be completed by the appellant (person filing the request for review or appeal).
Select one:

- ☐ Primary account holder
- ☐ Applicant (not currently enrolled in a SEBB benefit)
- ☐ Dependent of primary account holder

SEBB organization (employer)

Appellant Social Security number

– –

Last name

First name | Middle initial | Suffix

Home phone number | Work phone number

– – | – –

Email address

Residential address line 1

Residential address line 2

City | State

ZIP/Postal Code | County

Country

Mailing address (if different from residential)

Mailing address line 2

City | State

ZIP/Postal Code | County

Country

Appellant's last name	First name	Middle initial

Other enrollee information (if appeal concerns individuals other than the appellant)

Enrollee 1

Last name

First name | Middle initial | Suffix

Social Security number

Enrollee 2

Last name

First name | Middle initial | Suffix

Social Security number

Enrollee 3

Last name

First name | Middle initial | Suffix

Social Security number

2 Describe your request for review or appeal

Describe the situation that led to your appeal and what you're asking for. Please be as detailed as possible. You may attach additional pages as needed.

3 Appellant signature

Sign and date this section. Keep a copy of this form for your records. Submit signed request to your employer for review, if applicable.

By signing or submitting this form, I declare that the information I have provided is true, complete, and correct.

Signature

Date (mm/dd/yyyy)

Appellant's last name | First name | Middle initial

4 Employer response to employee's request for review

Instructions for employers

Complete Sections 4–6 (as applicable) to provide the requested review of your decision about the employee's eligibility for benefits, enrollment, or a premium surcharge.

1. Complete Section 4 and Section 6 **after** the employee completes Sections 1–3; see WAC 182-32-2020 for guidance.
2. **In addition, complete Section 5 if you agree that an incorrect decision or action occurred**.

    a. If correcting an enrollment error as described in WAC 182-30-060, forward your recommendation for correction of the enrollment error by secure email to the SEBB Program for final determination.

    b. For life or long-term disability insurance eligibility, enrollment, or premium issues, forward your recommendation to correct the decision or action caused by delay or error by secure email to the SEBB Program for final determination. Send a secure online message at **hca.wa.gov/fuze-questions**. you must set up a secure login for this feature.
3. Section 6 must be signed by a staff person who **did not** participate in the initial denial or decision-making process.
4. After completing all required sections:

    a. Return this form to the employee **within 30 calendar days** of receipt.

    b. Provide a copy to your agency administrator (or designee) for their records.

If the employer does not render a decision **within 30 days**, the employee may contact the SEBB Appeals Unit. To be completed by the employer.

SEBB organization (employer)

School

Organization contact last name

Contact first name

Contact phone number

Contact's email

Date you received the employee's completed and signed request for review.

/ / (mm/dd/yyyy)

Full name of person and job title who made this initial denial or decision on the *Employee's Request for Review*

Last name

First name

Title

Appellant's last name | First name | Middle initial

Date of agency decision on *Employee's Request for Review*. The next level of appeal must be received by the SEBB Appeals Unit **within 30 days of this date.** Employer fills in date of organization's decision.

/ / (mm/dd/yyyy)

If your initial appeal is confirmed as received by HCA by your appeal deadline, it will be considered timely. All future appeal-related deadlines must be received by the SEBB Appeals Unit within the relevant timeframes to be considered timely.

Check one (Employer must check one box):

- ☐ This appeal relates to a decision made by the SEBB Program. The employee is responsible for complying with the timelines described on page 1 to appeal to the SEBB Appeals Unit.
- ☐ The employer stands by the decision. The employee has the right to appeal this decision by completing Section 7. The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the date of the employer's review decision.
- ☐ The employer believes that an incorrect decision or action occurred, and must complete Section 5.

5 Employer response (optional)

To be completed by the employer only if an incorrect decision or action occurred.

Why do you believe an incorrect decision or action occurred?

- ☐ SEBB organization delay
- ☐ SEBB organization error

Please explain the delay or error:

The employer recommends the following to correct the decision or action:

6 Employer signature

To be completed by the employer's administrator or designee after completing Sections 4–5 as required. This section must be signed by a staff person who did not participate in the initial denial or decision-making process under appeal.

Reviewer's last name

Reviewer's first name | Reviewer's phone number

– –

Reviewer's signature | Date (mm/dd/yyyy)

/ /

Appellant's last name	First name	Middle initial

7 Employee notice of appeal to the SEBB Appeals Unit

Instructions for employees: Do not complete this section until you receive a completed copy of this form from your employer, unless you are directly appealing a decision made by the SEBB program.

- If you wish to appeal your employer's decision, or you agree with your employer's belief that an incorrect decision or action occurred, sign and date this section and submit this form to the SEBB Appeals Unit as instructed below.
- You may attach a statement that identifies the specific portion of the decision you are appealing. You may explain why you agree or disagree with the employer's decision and submit additional documentation for review.
- The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's review decision date in Section 4.

Your appeal must comply with all deadlines on page 1.

To be completed by the appellant.

Response to your employer's reason for denial above.

Additional information you want the SEBB Appeals Unit to consider, not previously stated above.

Are you attaching additional documentation? Please identify the document and the reason you are submitting it.

☐ No

☐ Yes. I have attached additional documents, such as forms or correspondence between my employer or the SEBB Program and me.

Appellant's last name | First name | Middle initial

8 Representative information (optional)

If you have someone representing you, you must complete HCA's *Authorization for Release of Information* form. Please contact the SEBB Appeals Unit for additional information at 1-800-351-6827.

Last name

First name | Middle initial

Phone number

– –

Relationship to appellant applicable)

Washington State Bar Association number (If

Mailing address line 1

Mailing address line 2

City | State

ZIP/Postal Code

9 Appellant signature

Sign and date this section. Keep a copy of this form for your records.

By signing this form, I declare that the information I have provided is true, complete, and correct.

Signature

Date (mm/dd/yyyy)

/ /

How to submit this form

! The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's review decision date in Section 4 to request a brief adjudicative proceeding. Submit this completed form by mail or fax (choose one):

Mail
Health Care Authority
Attn: SEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Fax
360-763-4709