INSERT SCHOOL DISTRICT LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE NAME,

Review of your account and 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.

To correct the error, you will be enrolled in default benefits the first day 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 **require** enrollment as single subscriber in the following default plans (WAC 182-30-080(1)(b)):

* Uniform Medical Plan (UMP) Achieve 1, Uniform Dental Plan, MetLife vision insurance
* Basic Life insurance, Basic Accidental Death, and Dismemberment (AD&D) insurance
* Employer-paid Long-term Disability (LTD) insurance and employee-paid Long-term Disability (LTD) insurance
* Dependents will not be enrolled
* A monthly tobacco use premium surcharge will be incurred (WAC 182-30-050).

**Recourse options** may be considered for SEBB program insurance for the 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, dental and vision 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 182-16-2010.

**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,

EMPLOYER 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 understand that by failing to submit completed enrollment forms within the allowed deadlines, I will be enrolled in default coverage, as described in WAC 182-30-080(1)(b).

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

[ ]  I request retroactive enrollment in default SEBB Program health insurance coverage effective back to \*\_\_\_\_\_\_\_\_\_\_\_\_.

 (\***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 to the following address:

INSERT RETURN ADDRESS