Month Day, Year

Dear Employee Name,

During a review of your eligibility for School Employee Benefits (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. However, we failed to enroll you in SEBB insurance coverage as elected (WAC 182-30-060).

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

**Medical, Dental and Vision 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:** Recourse may be considered for SEBB program insurance for the 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 parameters of WAC 182-30-060 (5)(a).

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 by submitting an appeal within 30 days if you do not agree with a recourse decision made by your employer or the SEBB program (WAC 182-32-2010).

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

Month Day, Year

**Please choose a recourse option, sign, date, and return the document in its entirety 31 days of this notice.**

I agree to prospective correction/enrollment in SEBB Program health insurance coverage, effective MM/DD/YYYY.  
 *\*I understand that I will be responsible for applicable premiums starting from the date selected above.*

I request retroactive enrollment in SEBB Program health insurance coverage to be effective \*\_\_\_\_\_\_\_\_\_\_\_\_.

(\***Employee to choose the start date** of coverage between MM/DD/YYYY and MM/DD/YYYY)

*\*I understand that I will be responsible for applicable premiums starting from the date selected above.*

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

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

Return document to the following address:

INSERT RETURN ADDRESS