Attachment 4: Information Provided Does Not Verify Family Member Eligibility

For Employing Office/Tribal Employer Use

[INSERT DATE]

[INSERT EMPLOYEE NAME AND ADDRESS]

We have reviewed the documents you submitted to verify FEHB eligibility for your family member(s). Based on our review, the documents are not sufficient to verify eligibility. Therefore, we have determined that the person(s) listed below are not eligible for coverage under your FEHB enrollment effective [INSERT DATE]

1. [INSERT NAME OF INELIGIBLE FAMILY MEMBER]
2. [INSERT NAME OF INELIGIBLE FAMILY MEMBER]

The documentation submitted was not approved due to:

[INSERT REASON]

Please contact us to discuss whether these individuals may be eligible for either temporary continuation of coverage (TCC) or spouse equity coverage.

This is an initial decision. You or the affected person have the right to request that we reconsider this decision. A request for reconsideration must be filed with the employing office listed below within 60 calendar days from the date of this letter. A request for reconsideration must be made in writing and must include your name, address, Social Security Number (or other personal identifier, e.g. plan member number), your family member's name, the name of your FEHB plan, reason(s) for the request, and, if applicable, retirement claim number. Please also include a copy of this letter.

Requesting reconsideration will not change the effective date of removal listed above. However, if the reconsideration decision overturns the removal of the family member(s), the FEHB Carrier will reinstate coverage retroactively so there is no gap in coverage.

Send your request for reconsideration to:

[INSERT CONTACT INFORMATION]

The above office will issue a final decision to you within 30 calendar days of receipt of your request for reconsideration. If you need more time to submit your reconsideration request, please contact the employing office listed above in writing.

If the removal of the ineligible family member(s) results in your enrollment decreasing from three or more individuals to two individuals or from two individuals to one individual, you are eligible to decrease your enrollment type to Self Plus One or Self Only, respectively, within 60 calendar days. Contact us to submit a Standard Form (SF) 2809 (Event Code 1C) to request the

change in enrollment type. We encourage you to consider reducing your enrollment type since that may decrease your FEHB premium costs.

As a reminder, any intentionally false statement or willful misrepresentation, such as including ineligible family members on a health insurance plan, is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years or both (18 USC 1001), and may be subject to investigation.

If you have questions about this letter, you may contact us at:

[INSERT EMPLOYING OFFICE/TRIBAL EMPLOYER INFO]

[SIGNATURE]

cc: [FEHB Carrier]