Attachment 3: VERIFICATION DOCUMENTS NOT RECEIVED

[INSERT DATE]

[INSERT EMPLOYEE NAME AND ADDRESS]

On [INSERT DATE OF INITIAL REQUEST NOTICE] we notified you that we are requesting documentation to verify whether the person(s) listed below are eligible for coverage under your Federal Employees Health Benefits (FEHB) Program enrollment. Our records show that the following person(s) are being provided coverage under your [(Self Plus One) (Self and Family)] enrollment:

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

In order to verify eligibility, we requested that you submit to us appropriate documentation that demonstrates the relationship between you and each listed person.

Because we have not received a reply from you, we must remove the above listed person(s) from your FEHB enrollment. This means the person(s) listed will no longer have coverage under your FEHB enrollment.

The effective date of removal is [INSERT REMOVAL DATE – DAY 61].

Please contact the employing office listed below to discuss whether these individuals may be eligible for temporary continuation of coverage (TCC).

This is an initial determination. You or the affected person have the right to request reconsideration of 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/we] will reinstate coverage retroactively so there is no gap in coverage.

Send your request for reconsideration to:

[INSERT EMPLOYING OFFICE 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 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 days. We encourage you to consider reducing your enrollment type since that may decrease your FEHB premium costs.

You must contact your employing office and submit a Standard Form (SF) 2809 (Event Code 1C) to request the change in enrollment type.

Any intentional false statement or willful misrepresentation, such as including an ineligible family member on a health insurance plan, is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of 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 CONTACT INFORMATION]

[SIGNATURE]

cc: [Employing Office/FEHB Carrier]