<Date>

<First Name, Last Name>

<Street Address>

<City, State, ZIP>

Dear <First Name>,

According to our records, you are averaging 30 or more hours a week and you are now eligible to enroll in the State’s High Deductible Health Plan (HDHP) offered through the State Health Plan. Your eligible HDHP coverage period begins on <plan start date> and could end after 12 months unless your employment ends prior to the 12 months or you are determine to still be eligible. You have 30 days to complete your enrollment.

Benefit information for the HDHP is available with your Agency Health Benefit Representative and/or on the State Health Plan website [www.shpnc.org](http://www.shpnc.org). If you have not already received the enrollment guide please request this information from your Health Benefit Representative. If you choose to enroll, you will be responsible for paying premiums directly to the vendor, as these premiums will not be deducted from your pay.

**To complete your enrollment:**

Visit [www.shphdhp.com](http://www.shphdhp.com) to enroll in benefits or call the vendor (COBRAGuard) directly for enrollment assistance at 855-442-6272.

**Rehired Retirees:**  If you are a rehired retired state employee you are eligible to enroll in the active State Health Plan. To enroll in the active State Health Plan and terminate your retiree State Health Plan please contact your HBR.  The HBR will add you to the rehire retiree active group so you can complete your enrollment within the 30 days of hire and your effective date of coverage begins <plan start date>.

If you do not wish to enroll in the HDHP plan or, as a rehired retiree in the active State Health Plan, and are waiving your health plan enrollment, please initial below and return this letter to your HBR. Please initial below to acknowledge receipt of this insurance eligibility notification offer and return a copy of this letter to your HBR.

\_\_\_\_\_\_ I wish to waive my enrollment in the State’s High Deductible Health Plan.

\_\_\_\_\_\_ As a rehired retiree I waive my enrollment in the Active State Health Plan.

\_\_\_\_\_\_ I acknowledge receipt of this notification.

Thank you,