EMPLOYER REQUEST FOR HEARING

Print additional forms to request hearings for multiple employees.

IMPORTANT: While it may be helpful to get ahead of the issue by appealing the initial employer notification, any penalties for failure to comply with the section 4980H of the tax code (employer coverage mandate) will ultimately be determined by the IRS based on tax filings submitted after the end of the tax year.

An appeal is NOT a requirement. You can ask us to help you resolve this issue by calling the Appeals Program at 1-855-859-2512 for more information.

**required fields*

Today's date	Application ID # on notification*	Date on notification*

COMPANY/EMPLOYER INFORMATION			
Name of Business/Employer*	Employer Representative Name		Title
Business Mailing Address	City, State	Zip	Employer Representative Telephone #*
Employer Rep Email Address*	Did you offer the employee named below health insurance that meets the requirements of the Affordable Care Act? ☐ Yes ☐ No ☐ Not yet		How much do you charge an employee for your lowest cost plan that meets ACA requirements? $_____/month

EMPLOYEE INFORMATION		
Employee First Name*	Employee Last Name*	Employee's Work Phone #*

EMPLOYER REPRESENTATIVE SIGNATURE (REQUIRED)

I am authorized to represent the above-named business. On behalf of the business, I request WAHBE adjudicate a dispute between this employer and the employee. This employer disputes the employee's eligibility for Advanced Premium Tax Credits. The information provided in this form is true and correct, to the best of my knowledge.

Employer Representative signature* Date

X

Do NOT send any other documents or evidence with this form.

EMAIL to: appeals@wahbexchange.org
MAIL to: *WAHBE Employer Appeal*
PO Box 1757
Olympia, WA 98507-1757

FAX to: 360-841-7653

Questions? 1-855-859-2512