ALASKA TEAMSTER-EMPLOYER
WELFARE TRUST
520 E 34th Avenue, Suite 107
Anchorage, AK 99503

2019

COMPOSITE RATE OPEN ENROLLMENT FORM

Name	Social Security Number	Birth Date	Gender

Mailing Address	City	State	Zip Code

Phone Number	Email Address
( )	

IMPORTANT NOTICE

Open Enrollment period **(October 22, 2018 – November 24, 2018** provides you with an opportunity to add or drop eligible dependents, for coverage ***effective January 1, 2019***, under the Alaska Teamster-Employer Welfare Plan. **Late enrollments will not be accepted.**

If you do not wish to make changes during this Open Enrollment Period, your dependents will default automatically to those dependents you currently have enrolled in the Plan, and unless you qualify for Special Enrollment your next opportunity to change your coverage designation will be during the ***next*** annual Open Enrollment period **(currently scheduled for October 2019 – November 2019)** for coverage ***effective January 1, 2020***. All enrollments and/or changes requested herein are subject to the specific terms and conditions described in the Plan's Summary Plan Description Booklet.

Composite Rate members have automatic Family Plan Level Coverage

Family Plan Level: The Family Plan Level provides medical, dental, prescription drug and vision benefits to the Eligible Employee, their eligible Spouse, and their eligible Dependent children. **COST: $1,688.00**

☐ ***When completing this form, if you require additional space, please attach an additional page. Please check this box if additional pages are attached.***

➢ **I am *ADDING* one or more dependents to my coverage:** ☐ **YES (*please list below*)** ☐ **NO**

- Spouse Name: ________________________ SSN: ________________ DOB: ________
- Dependent Name: ________________________ SSN: ________________ DOB: ________

  Natural/Adopted ☐ Step Child ☐ *Other ________________
- Dependent Name: ________________________ SSN: ________________ DOB: ________

  Natural/Adopted ☐ Step Child ☐ *Other ________________
- Dependent Name: ________________________ SSN: ________________ DOB: ________

  Natural/Adopted ☐ Step Child ☐ *Other ________________

➢ **For the purpose of *Coordination of Benefits*, please provide *other insurance information* that you or your covered dependents have in the space below:**

Insurance Carrier's Name: ____

Policy/ID Number: ______________________ Group Number: ______________________

Telephone Number: ______________________ Policy Holder: ______________________

Covered dependents: ____

____

If you are electing the ***Employee-Plus Plan Level*** or ***Family Plan Level*** you will need to provide the following documentation to the Trust Office in the event it has not been previously submitted: ***(1)*** a marriage certificate if you are married, ***(2)*** birth certificates for your dependent children (including eligible adopted children, step children, and foster children) as well as ***(3)*** any applicable legal documentation (e.g. adoption/foster child papers and/or child custody/support documents).

If you choose not to enroll your eligible dependents during this Open Enrollment period, they will ***not*** be eligible for ***COBRA*** continuation coverage if your Plan coverage ends before the next enrollment opportunity.

If you are electing the ***Employee Only Plan Level***, your enrolled dependents will be automatically dropped from your Plan coverage**.** However, if you are required to provide Dependent coverage for any eligible children through a ***Qualified Medical Child Support Order***, you may not cancel Dependent coverage and a cancellation of that coverage will be rejected.

➢ **I am a former participant/dependent currently being covered by COBRA:** ☐ **YES** ☐ **NO**

I understand the election I have made for Plan Level coverage will be ***effective January 1, 2019*** provided that I am then eligible under the Plan by **(1)** active employment eligibility, **(2)** dollar bank reserve eligibility, or **(3)** COBRA eligibility and I have provided the required information and documents. I further understand that if the Plan Level coverage I have elected requires a contribution towards the cost of the plan coverage, I hereby authorize that a self-payment deduction be commenced in the appropriate amount.

______________________________ ______________________

Participant's Signature **Date**

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Did you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Call your Plan Administrator at 907/751-9700 or you may dial 800/478-4450 (toll free) for more information.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.