ALASKA TEAMSTER-EMPLOYER
WELFARE TRUST

2020

COBRA 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 21, 2019 – November 22, 2019**) provides you with an opportunity to change your COBRA coverage options ***effective March 1, 2020***, under one of the specific elections described below as well as the opportunity to add or drop eligible dependents under the Alaska Teamster-Employer Welfare Plan. **Late enrollments will not be accepted.**

If you do not wish to make changes within this Open Enrollment time period, your coverage will remain at the COBRA level you are currently enrolled in. If you remain eligible for COBRA, your next opportunity to change your COBRA coverage designation will be during the ***next*** annual Open Enrollment period **(October 2020 – November 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.

Select one of the COBRA levels explained below

I would like to make the following Open Enrollment election for my health care coverage:

☐	**Single Individual:**	**Cost: $1045.00 per month**
☐	**Employee & Children:**	**Cost: $1725.00 per month**
☐	**Employee & Spouse:**	**Cost: $2032.00 per month**
☐	**Employee, Spouse & Child(ren):**	**Cost: $2882.00 per month**

CONTINUED ON REVERSE SIDE →

☐ **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: _____
_____

I understand the election I have made will be ***effective March 1, 2020*** providing that I have been eligible under the Plan with **COBRA** eligibility. I further understand that if I elect not to enroll my Spouse, this form requires my Spouse's signature.

_____ _____
Participant's Signature **Date**

_____ _____
Spouse'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.