ALASKA TEAMSTER-EMPLOYER
WELFARE TRUST

2020

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 coverage options; ***effective January 1, 2020***, under one of the specific Plan Levels 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 during this Open Enrollment Period, your coverage will default automatically to the Plan Level you are currently enrolled in, 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 2020 – November 2020)** for coverage ***effective January 1, 2021***. 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 Plan Levels explained below

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

☐ **Employee-Only Plan Level:** The Employee-Only Plan Level provides medical, dental, prescription drug and vision benefits to the Eligible Employee only; it does *not* provide any dependent coverage. **Cost: $1,120.00 per month**

☐ **Employee-Plus Plan Level:** The Employee-Plus Plan Level provides medical, dental, prescription drug and vision benefits to the Eligible Employee and either (1) his/her Spouse ***or*** (2) his/her Dependent children; it does *not* provide coverage for both. ***Please select one only***: ☐ **Spouse** ☐ **Dependent Children** **Cost: $1,678.00 per month**

☐ **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: $2,238.00 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: _____
_____

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, 2020*** 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.