2024/2025 ENROLLMENT FORM—FULL-TIME EMPLOYEES

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 509-323-7614 • Website: www.aseahealth.org

1. CURRENT EMPLOYER

❏ State of Alaska (GGU–Local 52) ❏ State of Alaska (PSEA Local 803) | Date of Hire:

❏ PSEA Local 803 Office Staff ❏ City of Fairbanks ❏ City of Ketchikan

2. PARTICIPANT/EMPLOYEE INFORMATION

Last Name: First Name: Middle:

Date of Birth: Gender: Social Security Number:

Current Marital Status: ❏ Single ❏ Married ❏ Divorced ❏ Widowed ❏ Legally separated Date of Marriage/Divorce:

Mailing Address (street or PO box):

City/State/Zip:

Cell Phone: Home Phone:

E-mail:

3. CHOOSE YOUR HEALTH PLAN

❏ **Plan A: Full Plan for Employees and Families** (the default Plan if you do not enroll) **$295 monthly employee contribution**

❗ STOP!—If you choose PLAN A and you are enrolling your spouse, you must complete Section 4 below to avoid an additional $125/month spousal surcharge!

❏ **Plan B: Full Plan for Employees Only** **$140 monthly employee contribution**
You may choose Plan B only if you are single or all of your eligible family members have other health coverage.

❏ **Plan C: Supplemental Plan for Employees and Families** **$35 monthly employee contribution**
You may choose Plan C **only** if you and all of your eligible family members have other health coverage.

❏ **Plan D: Low Option Plan for Employees and Families** **$40 monthly employee contribution**

Before you enroll for Plan C (or Plan B, if you are married or have dependent children) call your other health plan to understand how it will work with the ASEA Health Plan (some plans, including Alaska Care, may limit coverage). **Regardless you must still enroll by the deadline!**

4. SPOUSE EMPLOYMENT (Must be completed if you are enrolling in Plan A and are enrolling your spouse)

A. Is your spouse currently employed? ❏ Yes ❏ No If no, skip to #5.

B. Is your spouse eligible* for, or entitled to be offered, health benefits through his or her employer? ❏ Yes ❏ No If no, skip to #5.

C. Is your spouse enrolled in health benefits through his or her employer? ❏ Yes ❏ No*

*If your spouse is eligible for, or entitled to be offered, health coverage through his/her employer but declined coverage or failed to enroll timely, **a $125 per month surcharge will be added to your payroll deduction.**

5. HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)

❏ **Yes**, enroll me in a HCRA for 2024/2025 Plan Year, from which I will be reimbursed for eligible health care expenses that I incur.
(I understand that my monthly employee Health Plan contribution is NOT eligible for HCRA reimbursement.)
Deduct $_____.00 (min. $20, max. $266.67) per month from my paycheck for my monthly HCRA contribution.
❏ Check here to authorize the Health Trust to automatically submit the unpaid portion of your health claims to your HCRA (available only if you do not have other health coverage).

❏ **No**, I do not want to participate in the Health Care Reimbursement Account (HCRA).

6. DEPENDENT(S) TO ENROLL—SPOUSE/CHILDREN (List additional dependents on a separate sheet)

Please list all dependents that you wish to be covered. Eligible dependents that may be covered under the Plan are your spouse and children as defined by the Plan. Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS. Please note the Trust requires the following documentation: *Children*—Copy of the State Certified Birth Certificate Decree/ Court appointed/adoption papers. If divorced or legally separated, include a complete copy of the decree, custodial and/or financial order. *Spouse*—Copy of the State issued Certificate of Marriage. (Dependents will NOT be covered until the required documentation is received.)

Last Name: First Name: MI: Gender:

Relationship: Date of Birth: Social Security Number:

Last Name: First Name: MI: Gender:

Relationship: Date of Birth: Social Security Number:

Last Name: First Name: MI: Gender:

Relationship: Date of Birth: Social Security Number:

7. OTHER HEALTH CARE COVERAGE—Choose one (Use additional paper if needed)

❑ **I do NOT have other health care coverage for myself, my spouse or my other dependents.**

❑ **I DO have other health care coverage (including Indian Health Services, Denali Kids, Medicare or Medicaid) for myself, my spouse or my other dependents** (provide information below):

Insurance Co.: Phone Number:

Address:

Policyholder Name: Policyholder Date of Birth:

Policy Number: Effective Date:

Type of plan: ❑ Active ❑ Retiree Coverage provided: ❑ Medical ❑ Dental ❑ Vision ❑ Prescription

Please list all family members (including you) enrolled in this health plan:

8. CONFIRMATION—Sign below to indicate you have read and understand:

I select the benefits as indicated above for the July 1, 2024–June 30, 2025 Plan Year.

I understand that I may not make midyear benefit changes unless I have a Qualifying Event in my family, such as marriage, birth or adoption of a child, and changes in other health coverage. You must notify the Trust of a Qualifying Event within 60 days. Learn more at aseahealth.org under Your Life Changes.

I further understand that failure to disclose my spouse's eligibility and enrollment in employer-sponsored health care coverage (Section 4) could result in the **retroactive assessment of the $125/month surcharge on a post-tax basis**.

By signing below, I certify all information provided on this form is true, correct and complete to the best of my knowledge and I hereby further authorize my Provider of service to release any medical or other information necessary to process claims. A photocopy will be considered the same as the original.

Participant's Signature: **Date:**