2025
STATUS CHANGE/SPECIAL ENROLLMENT FORM

I am applying (check all that apply and provide the required documentation):

- ❑ **For new enrollment** (*) Marriage Certificate required and Birth Certificates required for dependent children; unless already provided.
- ❑ **To add family members** (*) Marriage Certificate and Birth Certificates for Children Required; unless already provided.
- ❑ **To change status of a family member,** (i.e. divorce, death, or to update other insurance information). **Important!** Please provide copy of divorce decree, death certificate or proof of "other" insurance coverage.

Employee Information *(This section must always be completed when enrolling for the first time or making changes)*

Name	Last four of SSN	Birth Date	Gender

Mailing Address	City	State	Zip Code

Phone Number	Email Address
( )	

Marital Status

❑ Married Date of Marriage:	❑ Divorced
❑ Never Married	❑ Date of Divorce/Death of Spouse:

Select one of the Plan Levels explained below

I would like to make the following Enrollment Plan Level election changes 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: $1,505.00 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: $2,255.00 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: $3,007.00 per month**

CONTINUED ON REVERSE SIDE ⟶

SPOUSE AND DEPENDENT INFORMATION: All information requested must be completed. If any item is not applicable, write "N/A"

Add	Terminate	Relationship	Social Security Number REQUIRED	Full, Legal First Name	MI	Full, Legal Last Name	Gender F/M	Date of Birth MO/DA/YR	Is this dependent covered by another plan? (See below)
		Spouse							Y☐ N☐
		Child Natural/Adopted ☐ Step Child ☐ *Other _____							Y☐ N☐
		Child Natural/Adopted ☐ Step Child ☐ *Other _____							Y☐ N☐
		Child Natural/Adopted ☐ Step Child ☐ *Other _____							Y☐ N☐
		Child Natural/Adopted ☐ Step Child ☐ *Other _____							Y☐ N☐

OTHER CURRENT COVERAGE:

➢ **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: _____

_____

Note: If you or your dependents become eligible for and/or enrolled in other coverage you are required to notify the plan in writing within 60 days. Failure to notify the plan of other coverage and/or any false statements or misrepresentation on this form is considered fraudulent and may result in retroactively terminating plan coverage and you will be responsible for reimbursement for all amounts paid in connection with such coverage, including claims incurred.

Is the insurance of any above dependents by a divorce decree/court order? ☐ No ☐ Yes

If yes, please include the portion of the decree that shows responsibility for medical expenses (unless already provided).

*CHILD CUSTODY INFORMATION: An employee's dependents as defined in the summary plan description. Please provide custody information including where the child resides, who has legal custody, and a copy of divorce decrees, court orders, and Qualified Child Medical Support Orders as applicable (unless already provided).

I certify that I have read the instructions and that the above information is complete and accurate. I also certify that all claims submitted will be only for me or for my dependents that are eligible for benefits under the plan. I understand that I will be responsible to reimburse the Trust fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information.

PLEASE SIGN X _____ Date Signed _____

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.

Special Enrollment for Qualified Status Changes

Special Enrollment Periods are provided when qualifying events occur and allow eligible participants and dependents to enroll or request changes to plan elections outside of Open Enrollment Periods. Once you have made your coverage election during this ***initial*** Open Enrollment period, the following Qualifying Events will apply in order to add/drop Family Coverage under the Alaska Teamster-Employer Welfare Plan.

Enrollment and changes requested within a Special Enrollment Period must be completed **within 60 days** of the qualifying event and may require supporting documentation. If enrollment or changes are not completed **within 60 days** of the qualifying event, the enrollment or plan election changes may not be made until the next Open Enrollment Period.

Qualifying Events Supporting Enrollment:

- **Marriage** - A new eligible dependent acquired through marriage must be enrolled **within 60 days** of date of marriage. Coverage will be effective as of the date of marriage. *Required Documentation: Status Change Enrollment form. Additional documentation of marriage date may also be required (i.e. marriage certificate).*
- **Divorce** – In the event of a divorce or dissolution of marriage, the Plan Participant may elect to drop Family Coverage and elect Individual Coverage provided the status change request is submitted to the Alaska Teamster-Employer Welfare Plan **within 60 days** from the effective date of the divorce or dissolution of marriage. *Required Documentation: Status Change/Enrollment form. Additional documentation may also be required (i.e., a copy of the divorce decree or dissolution of marriage paperwork filed with the courts.)*
- **Birth** - An enrollment form must be submitted **within 60 days** of the child's date of birth. Arrangements must be made to pay any applicable premium. Any applicable premium will be calculated from the child's date of birth. *Required Documentation: Status Change/Enrollment form. Additional documentation of birthdate may also be required (i.e., birth certificate).*
- **Adoption or Placement for Adoption** - New eligible dependent(s) acquired through adoption or placement for adoption must be enrolled **within 60 days** of adoption or placement for adoption. Coverage will be effective as of the date of adoption or placement for adoption. *Required Documentation: Status Change/Enrollment form. Additional documentation of adoption date may also be required (i.e., legal adoption papers).*
- **Loss/Gain of Other Coverage** - If an eligible participant or dependent were covered under another group health plan (including COBRA continuation) or had other medical insurance coverage when enrollment was declined, and has lost or will lose coverage under the other plan as a result of loss of eligibility (due to such reasons as death of a spouse, divorce, legal separation, termination of employment or reduction in the number of hours of employment or, cessation of the employer's contributions to such coverage) or exhaustion of COBRA continuation coverage, eligible participants and dependents must be enrolled **within 60 days** from the loss of other coverage. Coverage will be effective as of the date coverage was lost. Additionally, in the event an eligible spouse and other dependents becomes eligible under another group health plan (including COBRA continuation), the Plan Participant may elect to drop Family Coverage and elect Individual Coverage provided the status change request is submitted to the Alaska Teamster-Employer Welfare Plan **within 60 days** from the effective date of the other group health coverage. *Required Documentation: Status Change Enrollment form. Additional documentation of divorce, death of spouse or legal separation date or HIPAA certificate/letter from former plan, verification of other insurance coverage (e.g. letter of creditable coverage) may also be required.*
- **Qualified Medical Child Support Orders** - Eligible participants and dependent(s) may be enrolled in accordance with the terms of the order. *Required Documentation: Status Change Enrollment form. Additional documentation of court order may also be required.*