2020/2021 FLEXIBLE BENEFITS ENROLLMENT FORM for PART-TIME EMPLOYEES

ASEA Health Benefits Trust

Please see the 2020/2021 Health Benefits Open Enrollment Guide for more information about your benefits.

Member name: Health Plan ID:

Current employer:

❑ State of Alaska (GGU–Local 52) ❑ State of Alaska (PSEA Local 803) ❑ PSEA Local 803 Office Staff

❑ City of Fairbanks ❑ City of Ketchikan

1. CHOOSE YOUR HEALTH PLAN—Choose one

If you do not enroll, you will not have coverage for 2020/2021 (there is no default coverage for part-time employees).

❑ **Plan A: Full Plan for Employees and Families** **$1,072.50 monthly employee contribution**

❑ **Plan B: Full Plan for Employees Only** **$917.50 monthly employee contribution**
You may choose Plan B only if you are single or all of your eligible family members have other health coverage (list in Section 4 below)

❑ **Plan C: Supplemental Plan for Employees and Families** **$812.50 monthly employee contribution**
You may choose Plan C only if you and all of your eligible family members have other health coverage (list in Section 4 below)

❑ **Plan D: Low Option Plan for Employees and Families** **$817.50 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!**

2. HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)—Choose one

❑ **Yes**, enroll me in a HCRA for 2020/2021 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. $229.00) 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).

3. SPOUSE EMPLOYMENT (MUST BE COMPLETED IF YOU ARE ENROLLING YOUR SPOUSE)

Please check one of the following:

a. Is your spouse currently employed? ❑ Yes ❑ No If no, go to Section 4

b. Is your spouse eligible* for health benefits through his or her employer? ❑ Yes ❑ No If no, go to Section 4
*Your spouse is considered eligible if his or her job position entitles them to be offered health benefits, even if your spouse declined coverage or failed to enroll timely.

c. Is your spouse enrolled in health benefits through his or her employer? ❑ Yes ❑ No*
*If your spouse is eligible for health coverage through his/her employer but did not enroll in that coverage, **a $125 per month surcharge will be added to your payroll deduction.**

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4. 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):

Policyholder:		Policyholder's date of birth:
Policy number:	Effective date:	Type of plan: ❑ Active ❑ Retiree
Employer:		Insurance Co.:
Insurance Co. phone:	Address:	

Coverage provided: ❑ Medical ❑ Dental ❑ Vision ❑ Prescription

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

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

I select the benefits as indicated above for the July 1, 2020–June 30, 2021 Plan Year:

I understand that I may not make midyear benefit changes unless I have a Qualifying Event in my family:

- Marriage
- Birth or adoption of a child
- Divorce or legal separation
- Death of a dependent
- Dependent ceasing to be eligible or gaining eligibility
- Loss, gain or significant change in other health coverage (HCRA selections may not be changed following a change in other coverage)
- Changing from full-time to permanent part-time status or vice versa

If I have a Qualifying Event, **including loss of other health coverage**, I must notify the Trust Office and submit proof of the event and a new Benefits Enrollment Form **within 60 days**. Changes become effective the first day of the month after the Trust Office receives my submissions (or, for newborns or newly adopted children, retroactive to the date of birth or adoption).

I further understand that failure to disclose my spouse's eligibility and enrollment in employer-sponsored health care coverage (Section 3) 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 and correct.

Member Signature: **Date:**

6. ENROLL

- ENROLL ONLINE at www.aseahealth.org (click Online Enrollment) or securely by attaching this completed form to a message through Contact Us.
- Or, FAX this completed form to the Health Trust Administrator at 1-509-323-7614
- Or, MAIL this form to: ASEA/AFSCME Local 52 Health Benefits Trust, 111 W. Cataldo, Suite 220, Spokane, WA 99201