Public Education HEALTH TRUST

AEA
4003 Iowa Drive
Anchorage, AK 99517
907-274-7526 FAX 907-222-2556

Health Insurance Election/Waiver Form

☐New Hire ☐Qualifying Event
State Event: _____
☐Open Enrollment (see back of form for eligible events)

Social Security Number:	Name:	Sex M / F	Date of Birth: / /	Hire Date: / /
Mailing Address:	City:	State:	Zip:	
Home Phone:	Email:			
Work Phone:	Effective: _____/_____/_____ Authorized By: _____			

Part 1: **Election/Waiver Decision** PLEASE READ CAREFULLY CHECK ONE BOX ONLY

☐ Enroll me in Medical Plan C / Dental Plan B
☐ Enroll me in Medical Plan F / Dental Plan B

I certify that the information provided is true and correct to the best of my knowledge.
I hereby request coverage for an effective date on the first day of eligibility as per my contract and authorize deductions, as necessary, from my employee compensation for my share of the cost of benefits.
I understand my enrollment is irrevocable unless I have a qualifying event or until the next open enrollment/waiver period.

☐ Waive my Health Insurance Coverage Benefit

I acknowledge that I have been given the opportunity to participate in the Public Education Health Trust and that I elect NOT to participate. I understand that by declining to participate in the Plan at this time I also waive my ability to participate in the future except upon the occurrence of a qualifying event or as otherwise provided under the Plan.

Part 2: **Coverage for Dependents**

Dependent Information: Certificates required and must be received within 31 days of eligibility

For spouses, a copy of marriage certificate; for domestic partners, a statement of financial interdependency; for children, a copy of birth certificates or adoption agreement. The Plan must receive these documents prior to benefit payment for dependents. For each dependent you wish to have covered under the plan; please be sure to provide the name, date of birth and social security number below.

Last Name MI First	Date of Birth	Social Security Number	Relation

Part 3: **Other Insurance Coverage**

Do you or any of your covered dependents have other group health insurance? Yes or No (circle)

If Yes: _____ _____ ☐ ☐ ☐ _____
Health Insurance Company Name Group Name Medical Dental Vision Effective Date

Name of those covered under other policy: _____

Policy Holder: _____ Type of plan: ☐Group ☐Retiree ☐Individual ☐ Medicare ☐ COBRA

Part 4: **Authorization**

By my signature below, I agree to the Terms and Condition as listed on the reverse of this form.

Signed:_____ Date:_____