FAIRBANKS NORTH STAR BOROUGH
2023 HEALTH PLAN ENROLLMENT

Effective Date: January 1, 2023 Documents on File? Y / N __________ HR Initials: ______

EMPLOYEE INFORMATION:

______/_______/________ ____ _____/____/_____ _________
Social Security Number Last Name, First Name ,MI Date of Birth M / F

______________________________________ ______________________________ _________ __________
Mailing Address City State Zip Code

Is this a change of address? Yes ☐ **No** ☐ PhoneNumber:____________________EmailAddress:________________________________

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☐ **New Hire** ☐ **Add Dependents** ☐ **Delete Dependents** ☐ **Name Change** ☐ **Marriage** ☐ **Divorce (Previous Name:**______________ ☐ **Open Enrollment** ☐ **Other** __________

I Elect:

Medical/Rx	☐ **Employee Only**	☐ **Employee + Family**	☐ **Waive Med/Rx Coverage (*I have other medical coverage.)***
Dental/Vision/Audio	☐ **Employee Only**	☐ **Employee + Family**	☐ **Waive Dental/Vision/Audio Coverage**

Health Plan Waiver of Coverage Form must be completed if waiving employee Med/Rx coverage

I understand that Per Pay Period Deductions will be taken each payday as follows:

☐ **I elect Medical/RX as indicated above, and a deduction will be taken per pay period at the applicable rate as outlined in the collective bargaining agreement pertaining to my position.**

☐ **I elect Dental/Vision/Audio as indicated above. The deduction amount is $10 per pay period.**

I understand that because I elected Medical/RX and/or Dental/Vison/Audio above, I am required to establish a deduction for the Health Care Contingency Reserve Fund (HCCRF), in the amount of $10 per pay period (noted as POP on your paystub).

IF MARRIED: (Check all that apply)

☐ **My spouse is enrolled in medical coverage through his/her employer or is covered by a retiree plan. Spouses employer:**__________________________

☐ **My spouse declined health coverage offered by his/her employer, or my spouse elected a supplemental coverage plan which reimburses less than 50% of allowable charges. A surcharge of $200 per pay period will apply if this essentially shifts primary coverage to the Borough Medical Plan.**

All payroll deductions will be on a pre-tax basis unless you specifically direct otherwise.

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DEPENDENT INFORMATION:

Complete for each eligible dependent to be covered by this plan (Adult children up to age 26): Attach additional sheet if necessary.
Relationship Codes: **S** = Spouse; **C** = Natural Child/Step Child/Adopted Child /Legal Guardianship of Child.

Last Name, First Name MI	Gender M / F	Date of Birth	Social Security Number	Relationship Code	Other coverage? Y/N
		___/___/___	____/____/_____		
		___/___/___	____/____/_____		
		___/___/___	____/____/_____		
		___/___/___	____/____/_____		

I hereby certify that the above information is true, correct and complete to the best of my knowledge. I have received a copy of the current Health Plan and agree to comply with all Plan provisions as a condition of receiving benefits. I understand that benefits provided under the Health Plan for which a third party is or may be liable are subject to all of the subrogation and recovery provisions of the Plan. I have read and understand the options available to me regarding Health Benefits and understand I am unable to make any changes to my election during the calendar year unless I have a qualifying status change (marriage, divorce or legal separation, birth or adoption of a child, death of a dependent, dependent gaining or losing coverage, change in coverage under another employer plan, or a change in employment status) and have made my election change within 30 days of the date of the qualifying change. Failure to submit a timely change may carry financial consequences and/or the inability to make a change except during the open enrollment period. I will supply copies of the appropriate marriage and/or birth certificates, court-approved adoption (or fully executed adoption pre-agreement with appropriate parties), legal guardianship, divorce, and/or name change or other legal documentation when received, as well as the applicable FNSB forms for Adoption, Guardianship, or Name Change. The above information will be used to determine eligibility for claim/benefit purposes and I understand claims may be pended until the required documentation is received and processed.

I authorize the Fairbanks North Star Borough to make payroll deductions as reflected on this form.

____ ___________________________
Employee Signature Date

(Rev. 9/2018)