UA Choice Open Enrollment

Health Plan Enrollment Form for FY16

www.alaska.edu/benefits

UNIVERSITY of ALASKA
Many Traditions One Alaska

☐ 9, 10, 11 months (includes all UNAC and UAFT faculty members)

☐ 12 months

Please Print Legibly

Employee ID	Campus	Work Phone
Last Name	First	M.

To verify your current plan and coverage level, please log in to UAOnline.alaska.edu.
Requested changes will be reflected in UAOnline after June 13. Please check your account to verify accuracy.

I wish to enroll in (please choose one): FY16 Bi-Weekly Charges are listed on the reverse.

☐ **750 Plan** Office Use Only: [360, 361] [660, 661]

☐ **High Deductible Health Plan (HDHP)** Office Use Only: [370, 371] [670, 671]

☐ **Consumer-Directed Health Plan (CDHP)** Office Use Only: [380, 381] [680, 681]

Note: this plan works differently than the other plans. Please read the Enrollment Guide for details.
This plan qualifies for the Health Savings Account (HSA)

☐ **I wish to Waive Dental/Vision** (Note: waiving dental/vision coverage will not reduce your payroll deduction)
Office Use Only: [348]

To Opt Out (waive coverage) please complete the Opt Out Form
(If you are currently opted out of coverage, you do not need to complete this form unless you wish to enroll in a plan at this time.)

I elect this level of coverage (please choose all that apply):

☐ Employee Only (Required unless Opting Out)

☐ I want to enroll Spouse/Partner and/or children. Please see the attached Dependent Enrollment Form for FY16

I have read the statement of eligibility on the back of this form and certify that the dependents that I have listed as eligible dependents on the UA Choice Benefits Enrollment Form are accurate. I understand that if it is later proven that claims have been paid for an ineligible dependent, I will be totally responsible for the repayment of all services paid under the plan and may be subject to other administrative and/or legal actions, including but not limited to termination of employment.

I authorize the University of Alaska to reduce my salary in an amount equal to the cost of the applicable plan, in this and future years. I understand that this election cannot be revoked or changed until the next open enrollment, unless there is a loss of eligibility or life event. The change must be made within 30 days from the date of the life event. (Please contact your human resources office or refer to your benefits handbook for the life event definition.)

_____	_____	_____
Employee Signature	Date	Email Address

Submit this form to your regional human resources (HR) office no later than 5 pm Friday, May 15, 2015

Dependent Enrollment Form: Yes _____ No _____

Entered By: _____ Date: _____ DEDN Eff. Date: _____ BCOV Eff. Date: _____ Rev. 3/15

UA Choice Bi-Weekly Charges for FY16

	26 Payrolls				19 Payrolls			
	Employee Bi-Weekly Charge	Dependent Bi-Weekly Charge	Total Bi-Weekly Charge	Annual Charge	Employee Bi-Weekly Charge	Dependent Bi-Weekly Charge	Total Bi-Weekly Charge	Annual Charge
750 Plan								
Employee (EE)	$110.16	N/A	$110.16	$2,864	$150.74	N/A	$150.74	$2,864
EE + Spouse	$110.16	$127.54	$237.70	$6,180	$150.74	$174.53	$325.27	$6,180
EE + 1 Child	$110.16	$ 43.54	$153.70	$3,996	$150.74	$ 59.58	$210.32	$3,996
EE + 2 Children	$110.16	$ 78.35	$188.51	$4,901	$150.74	$107.22	$257.96	$4,901
EE + 3 or more Children	$110.16	$104.47	$214.63	$5,580	$150.74	$142.95	$293.69	$5,580
EE, Spouse, 1 child	$110.16	$171.08	$281.24	$7,312	$150.74	$234.11	$384.85	$7,312
EE, Spouse, 2 children	$110.16	$205.93	$316.09	$8,218	$150.74	$281.79	$432.53	$8,218
EE, Spouse, 3 or more Children	$110.16	$232.00	$342.16	$8,896	$150.74	$317.48	$468.22	$8,896
High Deductible Health Plan (HDHP)								
Employee (EE)	$65.81	N/A	$ 65.81	$1,711	$90.06	N/A	$ 90.06	$1,711
EE + Spouse	$65.81	$ 74.35	$140.16	$3,644	$90.06	$101.74	$191.80	$3,644
EE + 1 Child	$65.81	$ 21.35	$ 87.16	$2,266	$90.06	$ 29.22	$119.28	$2,266
EE + 2 Children	$65.81	$ 38.47	$104.28	$2,711	$90.06	$ 52.64	$142.70	$2,711
EE + 3 or more Children	$65.81	$ 51.27	$117.08	$3,044	$90.06	$ 70.16	$160.22	$3,044
EE, Spouse, 1 child	$65.81	$ 95.70	$161.51	$4,199	$90.06	$130.95	$221.01	$4,199
EE, Spouse, 2 children	$65.81	$112.77	$178.58	$4,643	$90.06	$154.32	$244.38	$4,643
EE, Spouse, 3 or more Children	$65.81	$125.58	$191.39	$4,976	$90.06	$171.85	$261.91	$4,976
Consumer-Directed Health Plan (CDHP)								
Employee (EE)	$52.35	N/A	$ 52.35	$1,361	$71.64	N/A	$71.64	$1,361
EE + Spouse	$52.35	$58.20	$110.55	$2,874	$71.64	$ 79.64	$151.28	$2,874
EE + 1 Child	$52.35	$14.66	$ 67.01	$1,742	$71.64	$ 20.06	$ 91.70	$1,742
EE + 2 Children	$52.35	$26.35	$ 78.70	$2,046	$71.64	$ 36.06	$107.70	$2,046
EE + 3 or more Children	$52.35	$35.12	$ 87.47	$2,274	$71.64	$ 48.06	$119.70	$2,274
EE, Spouse, 1 child	$52.35	$72.81	$125.16	$3,254	$71.64	$ 99.64	$171.28	$3,254
EE, Spouse, 2 children	$52.35	$84.54	$136.89	$3,559	$71.64	$115.69	$187.33	$3,559
EE, Spouse, 3 or more Children	$52.35	$93.31	$145.66	$3,787	$71.64	$127.69	$199.33	$3,787

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