Public Education HEALTH TRUST

AEA
2550 Denali St, STE 1614
Anchorage, AK 99503
907-274-7526 FAX 907-222-2556

Health Insurance Election/Waiver Form

☐ Qualifying Event: **Contract Ratification** February 4, 2026
Must be submitted to the Trust office
No later than 4:00 pm, March 6, 2026

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 C / Dental Plan B
☐ Enroll me in Medical F / Dental Plan B
☐ Enroll me in Medical HDHP / 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	Gender
				M / F
				M / F
				M / F
				M / F
				M / F

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 | Policy number | Medical | Dental | Vision | Effective Date | Phone number

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: _____

COMPLETION OF THIS FORM MEANS THAT YOU HAVE READ AND AGREE
TO COMPLY WITH THE FOLLOWING TERMS AND CONDITIONS:

- This form must be submitted directly to the Public Education Health Trust office at 2550 Denali St, STE 1614 or by faxing it to 907-222-2556.

- Select the health insurance option that most suits your personal needs.

- Submit required documentation. 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.

- If enrolling dependent(s) for coverage; I certify that they meet the requirements for dependent coverage. Any attempt to enroll individuals which do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law.

- Any enrollment or waiver change made in anticipation of a qualifying event such as a pending divorce will not be allowed. The covered spouse cannot be dropped from coverage until a divorce decree has been finalized.

- Qualifying Events are restricted to IRS defined events; these events as listed below allow a change mid-year to your previous election:
    - Open Enrollment (month of May for an effective date of July 1)
    - Birth/Marriage (notification required within 31 days of event)
    - Divorce (notification required within 31 days of event)
    - Death (notification required within 31 days of event)
    - Spouse is provided group insurance through employer for the first time (notification required within 31 days of event)
    - Coordination of spouse's annual election period (notification required within 31 days of event)

- Health plan participants should receive plan information and their I.D. cards in a timely manner. If you do not receive your I.D. card within 14 days of submitting this form, call the Public Education Health Trust office at 907-274-7526.

- Your effective date is governed by the collective bargaining agreement (CBA) and IRS eligible qualifying events.
    - New hires effective date, please refer to CBA or personnel policy manual.
    - Open enrollment changes, effective July 1st.
    - Qualifying event changes, if form is received within 31 days, change is effective the first of the month following the timely receipt of the required documentation. If form is received after 31 days of the event, the effective date would be at open enrollment.
    - Ratification of a collectively bargained agreement; effective the first of the month following the adoption of the agreement by the School District.

- I agree to the following terms for myself and my dependents: Unless otherwise prevented by law, we authorize health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance provider or its authorized representatives. Except as otherwise prevented by law; the insurance provider or its authorized representatives may share such information and provide it to other insurers, claims administrators, re-insurers, and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances relating to health benefit coverage and care. This authorization shall be valid for the duration of coverage. I acknowledge that I have obtained a copy of this authorization. I agree that a reproduced copy of this authorization will be as valid as the original.