ALASKACARE
Employee Health Plan

COBRA Health Continuation Enrollment

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
drb.alaska.gov

Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203

Juneau: (907) 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086

This form must be completed and returned or postmarked to the address above by November 26, 2025.
Contact the Division of Retirement and Benefits at (800) 821-2251 or in Juneau at (907) 465-4460 if you have questions.

1. MEMBER'S NAME			2. SOCIAL SECURITY NUMBER
3. PRIOR SOCIAL SECURITY NUMBER (IF APPLICABLE)	4. DATE OF BIRTH MM / DD / YYYY		5. SEX ☐ Male ☐ Female
6. MAILING ADDRESS (P.O. BOX OR STREET)			7. TELEPHONE NUMBER ( )
8. CITY	9. STATE	10. ZIP	11. EMAIL ADDRESS

12. MEMBER'S RELATIONSHIP (PLEASE CHECK ONE)

- ☐ Employee: Date Benefit Terminated MM / DD / YYYY
- ☐ Dependent: Date Health Coverage Ended MM / DD / YYYY
- ☐ Surviving Spouse: Date of Employee's Death MM / DD / YYYY
- ☐ Divorced Spouse: Date Divorce was Final MM / DD / YYYY

13. PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ I request coverage for my eligible dependents. *(Complete No. 14)* ☐ I request coverage for myself only. *(Skip to No. 15)*

14. MEMBER'S ELIGIBLE DEPENDENTS (IF APPLICABLE)

NAME OF ELIGIBLE DEPENDENT	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	DATE OF BIRTH
			MM / DD / YYYY
			MM / DD / YYYY
			MM / DD / YYYY

15. PLAN/COVERAGE

I would like the following health insurance program(*s*):

Medical Plan: ☐ Standard Plan ☐ Economy Plan ☐ Consumer Choice Plan

Dental Plan: ☐ Standard Plan ☐ Economy Plan

Coverage:

Medical:	☐ Self Only	☐ Self and Family	☐ None
Dental:	☐ Self Only	☐ Self and Family	☐ None
Vision:	☐ Self Only	☐ Self and Family	☐ None

MEMBER'S SIGNATURE	DATE MM / DD / YYYY

FOR STATE USE ONLY:

INSURANCE EFFECTIVE DATE MM / DD / YYYY	
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE MM / DD / YYYY

COBRA HEALTH CONTINUATION RIGHTS

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) ensures that you and/or your dependents will have the opportunity to continue your health insurance in certain circumstances where it would otherwise terminate.

COVERAGE:

You are eligible to purchase the same coverage you had at the time your coverage was terminated. If you need to review the details of your current benefit elections, please contact Inspira Financial at (800) 359-3921. If you have any other questions or need assistance, contact the Division of Retirement and Benefits by email at *doa.drb.benefits@alaska.gov* or by phone toll-free at (800) 821-2251 or in Juneau at (907) 465-4460.

The rates beginning January 1, 2026 are as follows:

COBRA Employee Only	
Medical, Standard	$ 1,624.46
Medical, Economy	968.50
Medical, Consumer Choice	793.61
Dental, Standard	64.31
Dental, Economy	29.99
Vision, Managed Care	13.68

COBRA Employee + Family	
Medical, Standard	$ 4,495.85
Medical, Economy	2,623.08
Medical, Consumer Choice	2,125.64
Dental, Standard	169.37
Dental, Economy	70.48
Vision, Managed Care	32.93

NOTE: These premiums are effective January 1, 2026. Premium amounts include the 2% administrative fee and are subject to change.

REMINDER:

Your premiums can be deducted directly from your bank account. If you are interested in this option, please see the *Inspira Financial Electronic Funds Transfer (EFT)* form.