ALASKACARE Retiree Health Plan

Retiree Health Dependent Change

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

Use this form to update your dependents or increase/decrease LTC or DVA coverage.

Please indicate your retirement system: ☐ PERS ☐ TRS ☐ JRS ☐ EPORS ☐ MEBA

SECTION I. PERSONAL DATA

(Please type or print clearly)

RETIREE NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER
CONTACT TELEPHONE NUMBER	EMAIL ADDRESS

1. DEPENDENT: ☐ **ADD** ☐ **DELETE** ☐ **EDIT**

DEPENDENT (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH
RELATIONSHIP ☐ Spouse ☐ Retiree's Child ☐ Retiree's Step-Child ☐ Other (specify) _____		MEDICARE ID NUMBER (MBI)
☐ Male ☐ Female	Full-time student ☐ No ☐ Yes	I am adding/deleting this dependent because of the following event: Date of the Event_____ ☐ Marriage ☐ Divorce ☐ Birth or Adoption ☐ Death ☐ Other (explain)_____
MAILING ADDRESS (IF DIFFERENT FROM RETIREE'S)		

2. DEPENDENT: ☐ **ADD** ☐ **DELETE** ☐ **EDIT**

DEPENDENT (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH
RELATIONSHIP ☐ Spouse ☐ Retiree's Child ☐ Retiree's Step-Child ☐ Other (specify) _____		MEDICARE ID NUMBER (MBI)
☐ Male ☐ Female	Full-time student ☐ No ☐ Yes	I am adding/deleting this dependent because of the following event: Date of the Event_____ ☐ Marriage ☐ Divorce ☐ Birth or Adoption ☐ Death ☐ Other (explain)_____
MAILING ADDRESS (IF DIFFERENT FROM RETIREE'S)		

3. DEPENDENT: ☐ **ADD** ☐ **DELETE** ☐ **EDIT**

DEPENDENT (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH
RELATIONSHIP ☐ Spouse ☐ Retiree's Child ☐ Retiree's Step-Child ☐ Other (specify) _____		MEDICARE ID NUMBER (MBI)
☐ Male ☐ Female	Full-time student ☐ No ☐ Yes	I am adding/deleting this dependent because of the following event: Date of the Event_____ ☐ Marriage ☐ Divorce ☐ Birth or Adoption ☐ Death ☐ Other (explain)_____
MAILING ADDRESS (IF DIFFERENT FROM RETIREE'S)		

4. DEPENDENT: ☐ **ADD** ☐ **DELETE** ☐ **EDIT**

DEPENDENT (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH
RELATIONSHIP ☐ Spouse ☐ Retiree's Child ☐ Retiree's Step-Child ☐ Other (specify) _____		MEDICARE ID NUMBER (MBI)
☐ Male ☐ Female	Full-time student ☐ No ☐ Yes	I am adding/deleting this dependent because of the following event: Date of the Event_____ ☐ Marriage ☐ Divorce ☐ Birth or Adoption ☐ Death ☐ Other (explain)_____
MAILING ADDRESS (IF DIFFERENT FROM RETIREE'S)		

SECTION II. DENTAL-VISION-AUDIO (DVA) BENEFITS

If applicable, update your DVA coverage to reflect the appropriate level of coverage based on the addition or deletion of dependents. Please note that you may only increase coverage or change DVA plans within 120 days of marriage, birth or adoption of your child, becoming a legal court-appointed guardian of a child, a change in your dependent's eligibility status (for example, a change in full-time student status), or during an open enrollment period.

	Change my DVA coverage to:	**I elect the following DVA plan:**
☐ No change needed	☐ No DVA coverage*	☐ Standard DVA plan
	☐ DVA coverage for myself (retiree) only	☐ Legacy DVA plan
	☐ DVA coverage for myself and my spouse	☐ No change needed
	☐ DVA coverage for myself, my spouse, and children	
	☐ DVA coverage for myself and children	

**By electing "No DVA coverage," you are electing to terminate your current DVA coverage for yourself and any dependents. If you discontinue participation, you waive all rights to future coverage and you are not eligible to re-enroll.*

SECTION III. LONG-TERM CARE (LTC) BENEFITS *(Note: this section does not apply to MEBA members)*

If you have chosen coverage for yourself and you marry, you may request coverage for your new spouse within 120 days after your marriage date. Your new spouse will be required to provide information on his or her health and will be subject to approval or denial by the claims administrator.

I elect the following LTC coverage for my spouse:

☐ Silver ☐ Gold ☐ Platinum

☐ I elect no LTC coverage for my spouse

☐ Cancel LTC coverage for my spouse

I elect to reduce coverage for myself (retiree) to:

☐ Silver ☐ Gold

☐ Cancel LTC coverage for myself (retiree)

SECTION IV. CERTIFICATION AND SIGNATURE

I acknowledge that if I do not elect LTC coverage for my new spouse or if I am dropping that coverage, I waive all rights to future coverage and I am not eligible to re-enroll. Changes in coverage are effective only after receipt of written request and are not retroactive.

I authorize the deduction of premiums from my benefit check for the coverage elected above.

I understand that my dependents between the ages of 19-23 are required to be registered at, and attending on a full-time basis, an accredited educational or technical institution recognized by the Department of Education and Early Development. I further understand that it is my responsibility to notify the Division of Retirement and Benefits if my dependent no longer meets the eligibility requirements as a dependent.

In completing this form, I acknowledge that a person who knowingly makes a false statement, or falsifies or permits to be falsified, a record of the retirement system in an attempt to defraud the system, is guilty of a class A misdemeanor, which, upon conviction, is punishable by a fine of not more than $500.00 or by imprisonment for not more than twelve months or both. AS 39.35.670; AS 11.56.210. I also acknowledge that a person who obtains funds and/or benefits by deception may be subject to prosecution for other crimes, including theft, which may be charged as misdemeanors or felonies with potential fines and penalties including imprisonment. I also acknowledge that a person who obtains funds and/or benefits from the system unlawfully may also be required to make restitution.

RETIREE SIGNATURE	DATE

SUBMITTING THIS FORM

- You may fax the form to the fax number listed at the top of the form.
- You may scan and then email the form to *doa.drb.benefits@alaska.gov.*
- You may mail the form to the address listed at the top of the form, attention "AlaskaCare."

RETIREE HEALTH DEPENDENT CHANGE FORM

You must use a "Retiree Health Dependent Change" form to list dependents to be added or deleted due to marriage, divorce, birth, death, adoption, or becoming the legal, court-appointed guardian of a dependent child. Please complete this form and return it to the Division of Retirement and Benefits along with your supporting documentation (for example, birth certificate, marriage certificate, court documents, etc. as applicable). Failure to complete this form when required may delay payment of claims for your dependent(s).

DEPENDENTS WHO ARE COVERED

The following dependents may be covered:

- Your spouse. You may be legally separated but not divorced.
- Your children from birth (exclusive of hospital nursery charges at birth and newborn care) up to 23 years of age only if they are:
  - Your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are legal, court-appointed guardian (if child is not your natural-born child);
  - unmarried and chiefly dependent upon you for support; AND
  - living with you in a normal parent-child relationship.
  - In addition, if they are between the ages of 19 and 23, they must be attending school regularly on a full-time basis.

  Children incapable of employment because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 23 and the children must continue to meet all other eligibility criteria, except for age and having to live with you in a normal parent-child relationship. You must furnish the Division evidence of the incapacity and proof that the incapacity existed before age 23. This proof must be provided no later than 60 days after their 23rd birthday or after the effective date of your retirement, whichever is later. Incapacitated children remain covered as long as the incapacity exists and you continue to provide periodic proof of the continued incapacity as required.

WHEN COVERAGE BEGINS

Eligible dependents are covered on the dates specified below.

If you elect or are provided with coverage for dependents, your dependents are eligible for benefits on the same day you are eligible if they meet all eligible requirements. If you add new dependents to your existing coverage, they will be covered under this plan immediately.

If you elect dependent coverage during an open enrollment period, your dependents are covered on January 1, assuming you pay the required premium.

If you increase your coverage to include dependents during an open enrollment or following marriage or birth of a child, their coverage begins on the first of the month following receipt of this form.

WHEN COVERAGE ENDS

If you are provided with or have elected coverage for your dependents, their coverage ends on the same day as your coverage ends, unless:

- you divorce. Coverage for your spouse ends on the date the divorce is final.
- your child no longer meets all eligibility requirements. Coverage ends at the end of the month in which your child first fails to meet these requirements.
- coverage is discontinued for all dependents.

There are several options available for continuing health coverage if one of the above situations occurs. Options are described in the "How to Continue Health Coverage" section of the *Retiree Insurance Information Booklet* or on the Division of Retirement and Benefits website at *AlaskaCare.gov*.