ALASKACARE
Retiree Health Plan

# Defined Benefit Retiree Direct Bill Open Enrollment

Aetna/Inspira Financial
P.O. Box 953374
St. Louis, MO 63195-3374

**FOR OFFICE USE ONLY**

**This form must be completed and returned or postmarked to the address above by the end of the open enrollment period. You will receive a monthly bill from Aetna/Inspira Financial based on your elections.**

| NAME | SOCIAL SECURITY NUMBER (SSN) | RETIREMENT IDENTIFICATION NUMBER (RIN) |
|---|---|---|
| | | |

| DATE OF BIRTH | SEX | MEDICARE ID NUMBER (MBI) (MEDICARE-ELIGIBLE MEMBERS ONLY) |
|---|---|---|
| | ☐ MALE ☐ FEMALE | |

| MAILING ADDRESS (P.O. BOX OR STREET) | CONTACT TELEPHONE NUMBER |
|---|---|
| | |

| CITY | STATE | ZIP CODE |
|---|---|---|
| | | |

I ELECT THE FOLLOWING HEALTH INSURANCE PROGRAM(S):

MEDICAL: ☐ SELF ONLY ☐ SELF & SPOUSE ☐ SELF & CHILDREN ☐ SELF & FAMILY ☐ NONE

DENTAL-VISION-AUDIO (CHOOSE EITHER STANDARD PLAN **OR** LEGACY PLAN):

STANDARD PLAN: ☐ SELF ONLY ☐ SELF & SPOUSE ☐ SELF & CHILDREN ☐ SELF & FAMILY ☐ NONE

LEGACY PLAN: ☐ SELF ONLY ☐ SELF & SPOUSE ☐ SELF & CHILDREN ☐ SELF & FAMILY ☐ NONE

DVA may be elected during Open Enrollment **only** if the same or increased level of medical coverage is also being elected for the first time. ☐ ☐ ☐ ☐ ☐

RETIREE'S ELIGIBLE DEPENDENTS (IF APPLICABLE):

| NAME | RELATIONSHIP | SOCIAL SECURITY NUMBER | DATE OF BIRTH | FULL-TIME STUDENT?* |
|---|---|---|---|---|
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |

RETIREMENT SYSTEM: ☐ PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS) ☐ TEACHERS' RETIREMENT SYSTEM (TRS)

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'S SIGNATURE | DATE |
|---|---|
| | |

# RETIREE DIRECT BILL HEALTH ENROLLMENT FORM

If your check is insufficient to cover the cost of the health plans you elected, you may pay the premiums directly to the claims administrator. You should complete this form and send it to Aetna/Inspira Financial at the address shown. They will bill you each month.

## PREMIUM RATE

| COVERAGE FOR: | MEDICAL | STANDARD DVA | LEGACY DVA |
|---|---|---|---|
| Retiree only | $ 791.52 | $ 78.54 | $ 81.60 |
| Retiree and spouse | 1,583.04 | 157.08 | 161.16 |
| Retiree and family | 1,910.46 | 223.38 | 229.50 |
| Retiree and child(ren) | 1,118.94 | 142.80 | 145.86 |
| Composite (system-paid) | 1,153.00 | | |

**NOTE:** These premiums are effective January 1, 2026. Includes 2% administrative fee. Premiums 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 enclosed Electronic Funds Transfer (EFT) form.