# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
## HUMAN RESOURCES DEPARTMENT
### 2024 Healthcare Enrollment

Check one: New Hire Add / Delete Dependent Marriage Divorce Other ______________________

Effective Date: _________ Part-time or Full-time

☐ **I Waive Medical Coverage (Waiver Form Required)**

☐ **I Waive Dental, Vision, and Audio**

| **Full-Time Employee Contributions** (per pay period) | Plan A | Plan B | Plan C | DVA |
|---|---|---|---|---|
| Employee Only | $914.00 | $6.00 | $165.00 | $16.00 |
| Employee & Spouse | $1,219.00 | $8.00 | $220.00 | $22.00 |
| Employee & Children | $1,219.00 | $8.00 | $220.00 | $22.00 |
| Employee & Family | $1,524.00 | $10.00 | $275.00 | $27.00 |

**Medical Plan Election** (must select Plan A, B or C, DVA Coverage, and indicate which family tier you elect)

Only employees currently on Plan A can enroll in Plan A

**EMPLOYEE INFORMATION:**

_____/_____/_____ ______________________________________ _____/_____/_____ _____ ________

**Social Security Number** **First Name, MI, Last Name** **Date of Birth** **M/F** **F Number**

**Address** **City** **State** **Zip Code**

**Phone Number:** ( ) ________________ **Email Address** ________________________

**DEPENDENT INFORMATION:**

**Complete for each eligible dependent to be covered by this plan**

Relationship Codes: **S** = Spouse (married); **C** = Natural Child/Step Child/Adopted Child /Legal Guardianship of Child

| First, MI, Last Name | Gender | Date of Birth | Social Security Number | Relationship |
|---|---|---|---|---|
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**Employee Name:**_________________________

I hereby certify that the above information is true, correct and complete to the best of my knowledge. I have received a copy of the current Health Plan and agree to comply with all Plan provisions as a condition of receiving benefits. I understand that this form will supersede any previous healthcare elections. I understand that benefits provided under the Health Plan for which a third party is or may be liable are subject to all of the subrogation and recovery provisions of the Plan. I have read and understand the options available to me regarding Health Benefits and understand I am unable to make any changes to my election during the calendar year unless I have a qualifying status change (marriage, divorce, birth, adoption, death or change in employment status) and have made my election change within 30 days of the date of the qualifying change. Failure to submit a timely change and supporting documentation may carry financial consequences and/or the inability to make a change except during the open enrollment period. Attached are copies of the appropriate marriage and/or birth certificates, court-approved adoption (or fully executed adoption pre-agreement with appropriate parties), legal guardianship, divorce, and/or name change or other legal documentation, as well as the applicable FNSB forms for Adoption, Guardianship, or Name Change. The above information will be used to determine eligibility for claim/benefit purposes. If you a) enroll a dependent who does not meet the eligibility requirements of this plan; or b) fail to notify the plan of your divorce or other loss of dependent eligibility within 30 days of the event; you are intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for your ineligible dependent. If the plan pays claims based on your misrepresentation, your dependent may be terminated retroactively and you may be responsible for any claims paid on your dependent's behalf. I authorize the FNSB School District to make payroll deductions to cover my share of the cost of this health benefit plan.

**OPTIONAL / VOLUNTARY BENEFITS** (must enroll each year)**:**

**Flexible Medical Spending Arrangement (Medical FSA)**
**(Minimum $200; Max $3,050 Annually)**

**$**__________________.__________ **= $**_____________
**Annual Election Amount** **Amount per pay period**

**Flexible Dependent Care Spending Account (Dependent FSA)**
**(Minimum $200; Max $5,000 Annually)**

**$**__________________.__________ **= $**_____________
**Annual Election Amount** **Amount per pay period**

**Health Savings Account (HSA)**
**(Eligible with Plan B ONLY)**
**(Maximum $4,150 Single or $8,300 Family)**

**$**__________________.__________ **= $**_____________
**Annual Election Amount** **Amount per pay period**

☐ **Yes, I elect to take the employer contribution to an HSA**

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______________________________________________________________

**Employee Signature** **Date**

Office Use Only:
Effective Date of Coverage:______________Docs on File? Y / N Missing Documentation:________________

Employer HSA contribution:______________Employer HRA contribution:____________HR Initials:_________