

# UA Choice

# R/V Sikuliaq Employees Only

## Health Plan Enrollment Form for FY24

[www.alaska.edu/benefits](http://www.alaska.edu/benefits)



UNIVERSITY  
of ALASKA  
*Many Traditions One Alaska*

- I am a New Hire
- I have experienced a Life Event  
Date of Life Event: \_\_\_\_\_

Employee ID	Campus	Work Phone
Last Name	First	M.

Use this form to elect a plan option. See the FY24 Enrollment Guide and the Summary of Benefits and Coverage (SBC) for each plan to help you make your decision. Use the Dependent Enrollment Form to add or drop dependents. Be sure to read and understand the coverage effective date information on the back of this form.

Coverage for R/V Sikuliaq employees is effective the date of hire or life event. Note, this is an exception to the effective date described in the Handbook and the UA Choice Enrollment Guide.

### I wish to enroll in the following medical plan

- Premium Health Plan** Office Use Only: [H60]
- Basic Health Plan** Office Use Only: [H70]
- High Deductible Health Plan (HDHP)** Office Use Only: [H80]  
Note: This HDHP works differently than the other plans. Please read the Enrollment Guide for details. This plan qualifies for the Health Savings Account (HSA) (other eligibility requirements may apply).
- I am opting out of health care** Office Use Only: [H00]

### I wish to enroll in the following dental plan

- Premium Dental Plan** Office Use Only: [H40]
- Basic Dental Plan** Office Use Only: [H30]
- I am opting out of dental care** Office Use Only: [H04]

### I wish to enroll in the vision plan

- Yes** Office Use Only: [H20]
- No** Office Use Only: [H02]

### I elect to cover enroll the following people (Do not complete if you are opting out of medical, dental, AND vision)

- Employee only coverage
- Dependent coverage (Spouse/Partner and/or children): Complete and submit the Dependent Enrollment Form for FY24

I authorize the University of Alaska to reduce my salary in an amount equal to the cost of the applicable plan, in this and future years. I understand that this election cannot be revoked or changed until the next open enrollment, unless there is a loss of eligibility or life event. The change must be made within 30 days from the date of the life event. (Please contact UA HR at [ua-benefits@alaska.edu](mailto:ua-benefits@alaska.edu) or refer to your benefits handbook for the life event definition.)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Email Address

**Please return the completed form to UA HR**

Dependent Enrollment Form: Yes \_\_\_\_\_ No \_\_\_\_\_

Entered By: \_\_\_\_\_ Date: \_\_\_\_\_ DEDN Eff. Date: \_\_\_\_\_ BCOV Eff. Date: \_\_\_\_\_ Rev. 7/18/23

### Important Information Concerning Health Plan Enrollment

All newly hired University of Alaska employees have a 30-day election period in which to choose their preferred health care plan and dependent coverage options. Coverage for R/V Sikuliaq employees is effective the date of hire or life event.

If you do not submit an enrollment form and/or if you do not opt out (waive coverage) within your 30 day election period, you will automatically be enrolled in the **Basic Health Plan, Basic Dental Plan, and Vision Plan for employee-only**.

Dependents can only be enrolled in the same plan an employee is enrolled in. Please provide backup documentation (i.e. birth or marriage certificate) for each of the dependents you are enrolling.

Name	Relationship	DOB	SSN

# RATES

## Medical, Dental & Vision Premiums

Premium contributions for comprehensive health benefits are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your bi-weekly contributions.

### MEDICAL

PREMIUM PLAN				
\$750 Individual Deductible, \$2,250 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	\$135.97	N/A	\$135.97	\$3,535.22
EE + SPOUSE	\$135.97	\$154.08	\$290.05	\$7,541.30
EE + CHILD(REN)	\$135.97	\$61.58	\$197.55	\$5,136.30
EE + FAMILY	\$135.97	\$225.50	\$361.47	\$9,398.22

  

BASIC PLAN				
\$1,250 Individual Deductible \$3,000 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	\$89.58	N/A	\$89.58	\$2,329.08
EE + SPOUSE	\$89.58	\$98.50	\$188.08	\$4,890.08
EE + CHILD(REN)	\$89.58	\$31.77	\$121.35	\$3,155.10
EE + FAMILY	\$89.58	\$135.50	\$225.08	\$5,852.08

  

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH OPTIONAL HEALTH SAVINGS ACCOUNT (HSA)				
\$1,500 Individual Deductible OR \$3,000 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	\$75.58	N/A	\$75.58	\$1,965.08
EE + SPOUSE	\$75.58	\$81.58	\$157.16	\$4,086.16
EE + CHILD(REN)	\$75.58	\$22.58	\$98.16	\$2,552.16
EE + FAMILY	\$75.58	\$106.66	\$182.24	\$4,738.24

### DENTAL

PREMIUM PLAN				
	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE"	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	\$7.97	N/A	\$7.97	\$207.22
EE + SPOUSE	\$7.97	\$8.24	\$16.21	\$421.46
EE + CHILD(REN)	\$7.97	\$7.47	\$15.44	\$401.44
EE + FAMILY	\$7.97	\$17.97	\$25.94	\$674.44

  

BASIC PLAN				
	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	\$3.16	N/A	\$3.16	\$82.16
EE + SPOUSE	\$3.16	\$3.43	\$6.59	\$171.34
EE + CHILD(REN)	\$3.16	\$2.04	\$5.20	\$135.20
EE + FAMILY	\$3.16	\$6.39	\$9.55	\$248.30

### VISION

	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	\$0.60	N/A	\$0.60	\$15.60
EE + SPOUSE	\$0.60	\$0.67	\$1.27	\$33.02
EE + CHILD(REN)	\$0.60	\$0.49	\$1.09	\$28.34
EE + FAMILY	\$0.60	\$1.30	\$1.90	\$49.40