AlaskaCare New Hire Acknowledgement Form

FOR OFFICE USE ONLY

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

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

Juneau: (907) 465-4460
TDD: (907) 465-2805
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The Division of Retirement and Benefits offers an array of health benefits for you to enroll in once hired into a covered position. Enrollment into a health benefit must be completed within 30 days, to learn more about each benefit visit AlaskaCare.gov.

If you have questions related to your health benefits as a new employee, contact the Division of Retirement and Benefits toll-free at (800) 821-2251, in Juneau at (907) 465-4460, or by email at doa.drb.benefits@alaska.gov.

SECTION I. CONFIRMATION

INITIALS	I understand that I have 30 days, starting from my first day of employment in a covered position, to complete my online health enrollment. For example, if my first day of employment is March 1, I have until close of business on March 30 to make my elections.
INITIALS	I understand that I can make changes to my elections within my first 30 days of employment. Elections in place at the end of this enrollment period, including default elections, are irrevocable until the next applicable open enrollment period or unless I have a qualified status change.
INITIALS	I understand that I will be defaulted into the Economy Medical and Economy Dental plans unless I make a different election within the 30-day enrollment period.
INITIALS	I elected dental, medical, and/or vision coverage and understand that elections made during open enrollment will remain in effect until the end of the benefit year, unless I terminate employment or have an employment change that makes me ineligible for coverage, or change elections due to a change in status or other applicable event.
INITIALS	I prepared a dependent enrollment form for my eligible children and spouse (Section 1.3.2 Eligible Dependents). It has been printed, signed, and submitted to the Division of Retirement and Benefits Eligibility Team via fax or mailing address listed on the form. I understand that my dependent will not be covered until the Division has received and processed my dependent enrollment form.
INITIALS	I understand I will be defaulted into the Employee Only plans if I do not enroll my dependents timely and elect the Employee and Family options.

SECTION II. CERTIFICATION AND SIGNATURE

I certify acknowedgement that I have read and understand the conditions listed above.	
NAME (PRINTED)	DATE OF HIRE
SIGNATURE	DATE