Alaska Electrical Health & Welfare Fund
701 E Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576
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BENEFICIARY ENROLLMENT/ELECTION FORM

BENEFICIARY IDENTIFICATION

First Name _____ Initial _____ Last Name _____ SSN _____

Mailing Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Sex ____ Phone Number _____ Other Medical Coverage? (If yes, please list.) _____

DECEASED RETIREE IDENTIFICATION

First Name _____ Initial _____ Last Name _____ SSN _____ Date of Death _____

DEPENDENT CHILDREN

First Name	Initial	Last Name	SSN	Date of Birth	Sex	Relationship	Other Medical Coverage (Y/N)

IMPORTANT NOTICE

A dependent spouse covered under the retiree health plan at the time of the retiree's death shall remain eligible for retiree coverage for the remainder of his/her lifetime. At such time as the surviving spouse becomes eligible for another source of health coverage (other than Medicare or Indian Health Services coverage), he/she will no longer be covered under this Fund's retiree plan. In the event the surviving spouse loses other coverage, he/she will be allowed re-entry into the retiree plan at normal retirement age (currently 58) or when he/she becomes Medicare eligible. Refer to this Fund's Summary Plan Description for more details regarding dependent eligibility.

Please select *one* of the options below:

- ☐ I authorize the Administrative Office to reduce my monthly pension benefit by the appropriate premium.
- ☐ My first payment is enclosed. I understand each subsequent monthly payment must be received by the Administrative Office prior to the due date (first of the month for which coverage is being purchased), or coverage will be suspended. Payments postmarked more than 30 days after the due date will not be accepted, and my retiree coverage will terminate and will not be reinstated.
- ☐ I am declining Retiree Health & Welfare Coverage.

Signature _____ Date _____

OFFICE USE ONLY: PREMIUM: $_____ PLAN NUMBER: _____ EFFECTIVE: _____ INITIALS: _____