



## City and Borough of Sitka Personnel Information Sheet

Date: \_\_\_\_\_

\_\_\_\_\_  
Name (First, Middle, Last) *Please Print*

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Birth date

\_\_\_\_\_  
Physical Address

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Driver's License Number      State

Gender:             Male     Female

Race: (circle one)

US Citizen:         Yes       No

Alaska Native

American Indian

Marital Status:     Single    Married

Asian or Pacific Islander

Black

Current Military:  Yes       No

Hispanic

White

### Benefits (office use only)

	<u>Type</u>	<u>Rate</u>
SBS Insurance		
Premera Health Insurance		
LifeWise Assurance		
Deferred Comp		
AFLAC		

## INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1 - Employee.** All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Preparer/Translator Certification.** The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

**Section 2 - Employer.** For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins.** Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

**Section 3 - Updating and Reverification.** Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C),
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

**Photocopying and Retaining Form I-9.** A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

**For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.**

**Privacy Act Notice.** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

**Reporting Burden.** We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response.** If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

**NOTE:** This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

# Employment Eligibility Verification

**Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.**

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

<p><b>I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.</b></p>	<p>I attest, under penalty of perjury, that I am (check one of the following):</p> <p><input type="checkbox"/> A citizen or national of the United States</p> <p><input type="checkbox"/> A Lawful Permanent Resident (Alien #) A _____</p> <p><input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____</p>
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Employee's Signature	Date (month/day/year)
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**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name		Date (month/day/year)
Address (Street Name and Number, City, State, Zip Code)		

**Section 3. Updating and Reverification.** To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility. Document Title: _____ Document #: _____ Expiration Date (if any): _____	

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	Date (month/day/year)
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## LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C		
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility		
<ol style="list-style-type: none"> <li>1. U.S. Passport (unexpired or expired)</li> <li>2. Certificate of U.S. Citizenship (<i>Form N-560 or N-561</i>)</li> <li>3. Certificate of Naturalization (<i>Form N-550 or N-570</i>)</li> <li>4. Unexpired foreign passport, with <i>I-551 stamp</i> or attached <i>Form I-94</i> indicating unexpired employment authorization</li> <li>5. Permanent Resident Card or Alien Registration Receipt Card with photograph (<i>Form I-151 or I-551</i>)</li> <li>6. Unexpired Temporary Resident Card (<i>Form I-688</i>)</li> <li>7. Unexpired Employment Authorization Card (<i>Form I-688A</i>)</li> <li>8. Unexpired Reentry Permit (<i>Form I-327</i>)</li> <li>9. Unexpired Refugee Travel Document (<i>Form I-571</i>)</li> <li>10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (<i>Form I-688B</i>)</li> </ol>	OR	<ol style="list-style-type: none"> <li>1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address</li> <li>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> </ol> <p style="text-align: center; font-weight: bold;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> <li>10. School record or report card</li> <li>11. Clinic, doctor or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. U.S. social security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>)</li> <li>2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>)</li> <li>3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (<i>Form I-197</i>)</li> <li>6. ID Card for use of Resident Citizen in the United States (<i>Form I-179</i>)</li> <li>7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)</li> </ol>

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**

**Statement Concerning Your Employment in a Job  
Not Covered by Social Security**

\*\*\*\*\*

**City and Borough of Sitka**

**Federal Tax ID: 92-0041163**

\*\*\*\*\*

**Employee Name :** \_\_\_\_\_

*(Please print)*

**Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

**Windfall Elimination Provision**

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to the Social Security publication, "Windfall Elimination Provision."

**Government Pension Offset Provision**

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security, \$500 - \$400 = \$100. Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to the Social Security publication, "Government Pension Offset."

**For More Information**

Social Security publications and additional information, including information about exceptions to each provision, are available at [www.socialsecurity.gov](http://www.socialsecurity.gov). You may also call toll free 1-800-772-1213, or, for the deaf or hard of hearing, call the TTY number 1-800-325-0778, or contact your local Social Security office.

**I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.**

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Form SSA-1945**

**Information about Social Security Form SSA-1945,  
Statement Concerning Your Employment in a Job Not Covered by Social Security**

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect any possible Social Security benefit entitlement as a spouse or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

# Form W-4 (2007)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners/Multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

**Nonresident alien.** If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_

**B** Enter "1" if:   
 { • You are single and have only one job; or   
 • You are married, have only one job, and your spouse does not work; or   
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. } . . . . . **B** \_\_\_\_\_

**C** Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** \_\_\_\_\_

**D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** \_\_\_\_\_

**E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . . . . **E** \_\_\_\_\_

**F** Enter "1" if you have at least \$1,500 of **child or dependent care expenses** for which you plan to claim a credit . . . . . **F** \_\_\_\_\_

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**G Child Tax Credit** (including additional child tax credit). See Pub 972, Child Tax Credit, for more information.   
 • If your total income will be less than \$57,000 (\$85,000 if married), enter "2" for each eligible child.   
 • If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children. **G** \_\_\_\_\_

**H** Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► **H** \_\_\_\_\_

For accuracy, **complete all worksheets that apply.**   
 { • If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.   
 • If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.   
 • If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b>		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074
Department of the Treasury Internal Revenue Service		► <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>		<b>2007</b>
1 Type or print your first name and middle initial.		Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code		4 <b>If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.</b> ► <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5		
6 Additional amount, if any, you want withheld from each paycheck		6		\$
7 I claim exemption from withholding for 2007, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . . ►		7		
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (Form is not valid unless you sign it.) ►		Date ►		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)

### Deductions and Adjustments Worksheet

**Note.** Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2007 tax return.

<b>1</b>	Enter an estimate of your 2007 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2007, you may have to reduce your itemized deductions if your income is over \$156,400 (\$78,200 if married filing separately). See <i>Worksheet 2</i> in Pub. 919 for details.)	<b>1</b>	\$ _____			
<b>2</b>	Enter: <table style="display: inline-table; vertical-align: middle; border-left: 1px solid black; border-right: 1px solid black; border-collapse: collapse;"> <tr> <td style="padding: 0 10px;">\$10,700 if married filing jointly or qualifying widow(er)</td> </tr> <tr> <td style="padding: 0 10px;">\$ 7,850 if head of household</td> </tr> <tr> <td style="padding: 0 10px;">\$ 5,350 if single or married filing separately</td> </tr> </table>	\$10,700 if married filing jointly or qualifying widow(er)	\$ 7,850 if head of household	\$ 5,350 if single or married filing separately	<b>2</b>	\$ _____
\$10,700 if married filing jointly or qualifying widow(er)						
\$ 7,850 if head of household						
\$ 5,350 if single or married filing separately						
<b>3</b>	<b>Subtract</b> line 2 from line 1. If zero or less, enter "-0-"	<b>3</b>	\$ _____			
<b>4</b>	Enter an estimate of your 2007 adjustments to income, including alimony, deductible IRA contributions, and student loan interest	<b>4</b>	\$ _____			
<b>5</b>	<b>Add</b> lines 3 and 4 and enter the total. (Include any amount for credits from <i>Worksheet 8</i> in Pub. 919)	<b>5</b>	\$ _____			
<b>6</b>	Enter an estimate of your 2007 nonwage income (such as dividends or interest)	<b>6</b>	\$ _____			
<b>7</b>	<b>Subtract</b> line 6 from line 5. If zero or less, enter "-0-"	<b>7</b>	\$ _____			
<b>8</b>	<b>Divide</b> the amount on line 7 by \$3,400 and enter the result here. Drop any fraction	<b>8</b>	_____			
<b>9</b>	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, page 1	<b>9</b>	_____			
<b>10</b>	<b>Add</b> lines 8 and 9 and enter the total here. If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 below. Otherwise, <b>stop here</b> and enter this total on Form W-4, line 5, page 1	<b>10</b>	_____			

### Two-Earners/Multiple Jobs Worksheet (See *Two earners/multiple jobs* on page 1.)

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

<b>1</b>	Enter the number from line H, page 1 (or from line 10 above if you used the <b>Deductions and Adjustments Worksheet</b> )	<b>1</b>	_____
<b>2</b>	Find the number in <b>Table 1</b> below that applies to the <b>LOWEST</b> paying job and enter it here. <b>However</b> , if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3."	<b>2</b>	_____
<b>3</b>	If line 1 is <b>more than or equal to</b> line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. <b>Do not</b> use the rest of this worksheet	<b>3</b>	_____
<b>Note.</b> If line 1 is <i>less than</i> line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.			
<b>4</b>	Enter the number from line 2 of this worksheet	<b>4</b>	_____
<b>5</b>	Enter the number from line 1 of this worksheet	<b>5</b>	_____
<b>6</b>	<b>Subtract</b> line 5 from line 4	<b>6</b>	_____
<b>7</b>	Find the amount in <b>Table 2</b> below that applies to the <b>HIGHEST</b> paying job and enter it here	<b>7</b>	\$ _____
<b>8</b>	<b>Multiply</b> line 7 by line 6 and enter the result here. This is the additional annual withholding needed	<b>8</b>	\$ _____
<b>9</b>	Divide line 8 by the number of pay periods remaining in 2007. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2006. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	<b>9</b>	\$ _____

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$510	\$0 - \$35,000	\$510
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	850	35,001 - 80,000	850
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 170,000	950	80,001 - 150,000	950
18,001 - 22,000	3	19,001 - 26,000	3	170,001 - 300,000	1,120	150,001 - 340,000	1,120
22,001 - 26,000	4	26,001 - 35,000	4	300,001 and over	1,190	340,001 and over	1,190
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



## HEALTH QUESTIONNAIRE

Company: \_\_\_\_\_

Name: \_\_\_\_\_  
                     Last                                    First                                    Middle                                    Position                                    Social Security No.

### PERSONAL MEDICAL HISTORY:

Please mark answers to all questions. If any of your answers to these questions are marked "yes," please provide a full explanation of the condition and any past or ongoing treatment on the reverse side. Please describe any restrictions on your physical activities which result from the condition. If necessary, use additional pages.

Have you ever had or have you ever been treated for:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
1. Allergies	_____	_____	25. Joint Injury or Pain	_____	_____
2. Amputated Foot, Hand or Leg	_____	_____	26. Kidney Problems/Disease	_____	_____
3. Ankylosis (fused joints)	_____	_____	27. Heavy Metal Poisoning	_____	_____
4. Arthritis/Rheumatism	_____	_____	28. Muscular Dystropies (wasting of muscles)	_____	_____
5. Arteriosclerosis (hardening arteries)	_____	_____	29. Muscular Strain	_____	_____
6. Asthma/Bronchitis	_____	_____	30. Multiple Sclerosis	_____	_____
7. Cardiac Disease or Heart Problems	_____	_____	31. Neck or Back Injury	_____	_____
8. Cerebral Palsy	_____	_____	32. Osteoporosis (loss of bone calcium-usually in women)	_____	_____
9. Cerebrovascular Disorder	_____	_____	33. Parkinson's Disease	_____	_____
10. Osteomyelitis (bone infection)	_____	_____	34. Poliomyelitis	_____	_____
11. Chronic Sore Throat	_____	_____	35. Head Injury	_____	_____
12. Compressed Air Sequelae	_____	_____	36. Ruptured Intervertebral Disc	_____	_____
13. Diabetes or Hyperinsulinism	_____	_____	37. Silicosis (lung condition from stone dust) or Abestosis	_____	_____
14. Epilepsy	_____	_____	38. Skin Rashes	_____	_____
15. Blindness (partial or complete) or Eye Problems	_____	_____	39. Spondylolisthesis (slippage of vertebrae from normal alignment)	_____	_____
16. Fainting/Dizzy Spells	_____	_____	40. Thrombophlebitis (inflamed vein with clots)	_____	_____
17. Fractures	_____	_____	41. Tuberculosis or Other Lung Problems/Disease	_____	_____
18. Headaches	_____	_____	42. Varicose Veins	_____	_____
19. Whole or Partial Loss of Hearing or Other Ear Problems	_____	_____	43. Other Problems, Diseases, Conditions	_____	_____
20. Hemophilia or Prolonged Bleeding	_____	_____			
21. Hemorrhoids or Rectal Bleeding	_____	_____			
22. Hernia	_____	_____			
23. High Blood Pressure or Hypertension	_____	_____			
24. Ionizing Radiation Injury	_____	_____			

Please answer the following questions. If the answer to any of these questions is "yes," please explain your answer in detail. Use additional pages if necessary:

Yes    No

\_\_\_\_    \_\_\_\_    Have you ever been hospitalized? If so, please state the date and place of hospitalization.

\_\_\_\_    \_\_\_\_    Have you ever been advised by a medical physician to restrict your physical activities in any way? Please explain any restriction in detail.

\_\_\_\_    \_\_\_\_    Are you currently taking any medication or drugs, whether by prescription or not? Or, have you taken any in the last 60 days? If so, list them.

\_\_\_\_    \_\_\_\_    Have you ever undergone surgery? If so, when and where?

\_\_\_\_    \_\_\_\_    Have you ever refused a recommended surgical procedure? If so, please describe the circumstances.

Employer does not discriminate in hiring, promotion or retention policies or practices against persons who have, in good faith, filed a claim for or received benefits under the Alaska Workers' Compensation Act.

I hereby certify that I have answered the above questions to the best of my knowledge and the answers are true and complete. I understand that misrepresentation or omission of facts is cause for dismissal and may result in denial of workers' compensation benefits.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**City and Borough of Sitka  
Benefits Summary**

1. **Vacation:** Years 1-3 - 13 days  
Years 4-7 - 19 days  
Years 8+ - 25 days  
May be taken after 6 months of permanent employment.  
Paid out at termination or retirement.  
480 hours maximum accrual at end of fiscal year.  
Twice per year, hours over 120 may be cashed out.
2. **Holidays:** Nine (9) per calendar year.
3. **Floating Holidays:** 20 hours  
Issued on anniversary date the first year and then on July 1st.
4. **Sick Leave:** Twelve (12) hours per month (1-2 days).  
720 hours maximum accrual.  
Payoff of \$1.00 per unused hour at termination or retirement.  
May convert maximum of 40 hours of sick leave to vacation each calendar year.
5. **Retirement:**

- **State of Alaska Public Employee Retirement System (PERS).**

All new employees who first become members on or after July 1, 2006, will be enrolled in either the Public Employees' Retirement System (PERS) Tier IV or Teachers' Retirement System (TRS) Tier III, Defined Contribution Retirement (DCR) Plan.

Both the member and employer contributions go into the member's account each pay period. Member is immediately vested in the balance of the member contributions. Member is not 100 percent vested in the employer contributions until five years of service is accrued. Listed below are the vesting requirements for the employer contributions:

- At two years of service the member is 25 percent vested in the employer contributions.
- At three years of service the member is 50 percent vested in the employer contributions.
- At four years of service the member is 75 percent vested in the employer contributions.
- At five years of service the member is 100 percent vested in the employer contributions.

- **State of Alaska Supplemental Benefit System (SBS)**

State plan to replace Social Security (FICA). 6.13% of gross before taxes matched by employer and is set up in an annuity account. Other life insurance may be purchased under this plan; cost varies per plan and is deducted before taxes.

- **FICA**

Employees hired after April 1, 1986, must participate in the Medicare portion of social security, 1.45% of gross matched by the employer.

- 6. Health:** **Blue Cross of Washington and Alaska**  
Employer pays 90%; employee pays 10% of monthly premium.  
\$350 Calendar Year deductible per enrollee, \$1050 per family.  
\$75 Emergency Room deductible (waived if admitted or accidental injury)  
\$25 Office Visit  
\$50 Dental deductible pays 80% on basic service.  
Vision – 1 exam per calendar year; \$300 hardware every two years
- 7. Life Insurance:** **LifeWise (States West Life)**  
Employee must be enrolled in health plan.  
\$2,000 Life, \$5,000 of AD & D  
Additional life insurance may be purchased, 100% employee paid.
- 8. Deferred Compensation:** **ICMA or Great West – 457 Plans**  
100% employee paid; no employer contributions.
- 9. Supplemental Insurance:** **AFLAC**  
Supplemental life insurance  
Accident  
Disability
- 10. Employee Assistance Program:** Work-related problem solving, through Libby Stortz, LSCW; Neurobehavioral Consultants, and Sitka Counseling and Prevention Services

City and Borough of Sitka  
**Benefits Contact Information**

<b>Company</b>	<b>Name</b>	<b>Email</b>	<b>Phone</b>
PREMERA BLUE CROSS	Sara Duncan	<i>Sara.Duncan@premera.com</i>	425-918-4518 1-866-358-2294 425-918-5543 fax
PERS	Melinda Voigt	<i>melinda_voigt@admin.state.ak.us</i>	907-465-4467 1-800-821-2251
SBS	Tim Wagner	<i>tim_wagner@admin.state.ak.us</i>	1-800-821-2251
GREAT WEST DEFERRED COMPENSATION	Steven Orchekowsky  Linda Ulrich	<i>steven.orchekowsky@gwrs.com</i>  <i>linda.ulrich@gwrs.com</i>	1-800-462-9277 425-646-6555 x 3213 425-646-6566 fax
ICMA DEFERRED COMPENSATION	Lisa Lauderback	<i>llauderback@icmarc.org</i>	1-800-291-9115 253-277-1776 253-277-1777 fax
LIFEWISE (formerly States West)	Sandra Nishimoto	<i>sandra.nishimoto@premera.com</i>	1-800-258-0394 425-918-4485 fax
AFLAC	Maria Thomas-Sowa	<i>maria_sowa@us.aflac.com</i>	907-229-3954 907-561-2890 fax
CITY & BOROUGH OF SITKA	Mark Danielson	<i>markd@cityofsitka.com</i>	907-747-1816
SUPPLEMENTAL INSURANCE	Karl Stedman	<i>karl@stedmanins.com</i>	907-747-8618



# City and Borough of Sitka

100 Lincoln Street • Sitka, Alaska 99835

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## **EMAIL ADDRESS SET UP FORM**

*Please return completed form to Human Resources.*

This information will be used by the IS department in setting up your email account. The password will remain confidential.

Most e-mail addresses with the City and Borough of Sitka are the first name. If that is already being utilized, add your last initial or use your last name, or an appropriate combination.

**Full Name:** \_\_\_\_\_

**Position Title:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_@[cityofsitka.com](mailto:cityofsitka.com)

*(This will be first [name@cityofsitka.com](mailto:cityofsitka.com), all lower case letters, unless there's already an employee with that first name. In that case, it will be first name plus first letter of the last name.)*

**Password:** \_\_\_\_\_

*(This password will be used for your email as well as for the Windows Operating System on your computer.)*

### **Routing:**

- Mary Ann (HR): \_\_\_\_\_
- Will (IS): \_\_\_\_\_
- Employee or Supervisor: \_\_\_\_\_

2550 Denali Street, Suite 1404  
Anchorage, AK 99503-2737

**MEMBER ENROLLMENT AND CHANGE APPLICATION**

NEW  CHANGE: Reason \_\_\_\_\_ Date of Event \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Select reason from list below)

**Enrollment Reasons:** New Employee, Rehired Employee, Open Enrollment, Plan Transfer, Employee Entered Eligible Class (please indicate part-time to full-time, temporary to permanent, hourly to salaried, etc.), Marriage, Legal Separation, Divorce, Death, Birth, Adoption (legal documents required), Dependent Change, and Involuntary Loss of Other Coverage

**GROUP NAME** \_\_\_\_\_  
**GROUP ID** \_\_\_\_\_  
**SUBGROUP ID** \_\_\_\_\_

**Note:** If you, your spouse or child are applying for COBRA, please complete and attach a COBRA enrollment form. COBRA is not available on all plans. Please check with your Group Benefits Administrator for details.

**1. GROUP INFORMATION (TO BE COMPLETED BY THE GROUP)**

Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_ Date employee entered eligible class \_\_\_\_/\_\_\_\_/\_\_\_\_  Same as hire date Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employee Job Title \_\_\_\_\_ Employee Class (if applicable) \_\_\_\_\_ Employee Location \_\_\_\_\_

**2. EMPLOYEE INFORMATION (EMPLOYEE TO COMPLETE SECTIONS 2-7)**

**Note:** Only 26 characters print on ID cards. Each member's full name must be limited to 26 total letters and spaces as you'd like it to appear on your ID cards.

**A. Name** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Social Security No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
(If different than home address)  
 Married  Unmarried Home Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_ eMail \_\_\_\_\_

**B.** If you call Customer Service, will you require an interpreter?  No  Yes, primary language spoken:  English  Spanish  Vietnamese  Russian  Korean  Other \_\_\_\_\_

**C. Plan Choices:** Medical Plan Name \_\_\_\_\_ Dental Plan Name \_\_\_\_\_

**3. ENROLLMENT INFORMATION**

**Note:** Please check the Add or Drop box for each enrollee. Use a separate sheet to list additional enrollees.

A. Add	Drop	Medical	Dental	Relationship to Employee	Last Name	First Name	Middle Initial	Social Security No.	Date of Birth (Mo/Day/Year)	Gender	Comments
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Self				- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> DP*				- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	

\*Domestic Partner (DP) coverage is not available on all plans. Please check with your Group Benefits Administrator for details.

**B.** Does a dependent have a different mailing address?  No  Yes, complete the following: Dependent's Name (Last, First, Middle) \_\_\_\_\_

Dependent's Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**C.** Is any child over the dependent age limit applying for coverage due to disability?  No  Yes, complete and attach the Request for Certification of Disabled Dependent.

**4. MEDICARE FOR EMPLOYEE AND ALL DEPENDENTS**

**A.** Is any person applying for coverage covered by Medicare?  No, go to section **5**  Yes, please complete **B**

**B.** Name Medicare ID # Effective Date: Part A / / Part B / / Reason:  Age  Disability  End Stage Renal Disease  
 Name Medicare ID # Effective Date: Part A / / Part B / / Reason:  Age  Disability  End Stage Renal Disease

**5. PRIOR COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS**

*Helpful Hint: Failure to complete prior coverage information could affect payment of claims.*

**A.** Has any person applying for coverage had health insurance coverage at any time during the 90-day period before your enrollment date on this plan?  
 No, go to section **6**  Yes, please complete **B**

*Notes: Some Groups have a waiting period before an employee is eligible for benefits. If you are not sure of your enrollment date, please contact your Group Benefits Administrator. Use a separate sheet to list additional prior carrier coverage.*

**B.** Prior Plan Name Prior Plan Phone Number ( ) Date Coverage Began / / Date Coverage Ended / /  
 Subscriber Name Subscriber ID Number  
 Policy covers:  Subscriber  Spouse  Dependent Children

**6. OTHER COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS**

*Helpful Hint: Failure to complete other coverage information could affect payment of claims.*

**A.** Will any person applying for coverage be covered under another plan after the coverage with this plan begins?  No, go to section **7**  Yes, complete **B, C and D**

**B.** If other coverage is another Premera Blue Cross Blue Shield of Alaska Plan, will this new Premera Plan replace your other Premera Plan?  No  Yes

**C.** Other Plan Name Other Plan Group Number Other Plan Phone Number ( ) Date Coverage Began / /  
 Subscriber Name Subscriber ID Number Policy covers:  Subscriber  Spouse  Dependent Children  
 Is this person covered as a retired or laid-off employee or is this person a covered dependent of such an employee?  No  Yes, enter the date retired or laid off / /  
 Type of Other Plan Policy:  Medical  Dental  Vision

**D.** If any dependent children are covered under another plan and the natural parents are divorced or separated, please provide the following information:

Child's Last Name	First Name	Middle Initial	Name of Person with Custody	Relationship to Child Listed	Name of Person with Financial Responsibility for Health Coverage	Relationship to Child Listed	Name of Other Coverage Provided*

\* If this coverage is different than the Other Plan as listed in section **6C** above, please list all Other Plan information on a separate sheet (e.g., name of policy holder, ID number, group number, date coverage began and phone number).

**7. EMPLOYEE SIGNATURE**

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supercede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

Employee Signature Date Signed / /

Premera Blue Cross Blue Shield of Alaska may collect, use and disclose protected personal information (PPI) about each individual enrolled under this application in order to carry out its routine business functions, which include, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. Premera Blue Cross Blue Shield of Alaska may also disclose PPI to state and/or federal agencies, or other third parties, as required or permitted by law.

2550 Denali Street, Suite 1404  
Anchorage, AK 99503-2737



## WAIVER OF COVERAGE

This is to confirm that I decline to participate in the Premera Blue Cross Blue Shield of Alaska program offered through my employer's group health plan as follows:

- I do not wish to enroll **myself**. I have other health care coverage.
- I do not wish to enroll **myself**. I do not have other health care coverage.
- I do not wish to enroll my  **spouse**  **children**.<sup>\*</sup> They have other health care coverage.
- I do not wish to enroll my  **spouse**  **children**.<sup>\*</sup> They do not have other health care coverage.

<sup>\*</sup>Please list the names of specific children you wish to waive if you are not enrolling all of them.

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have **involuntarily** lost your other coverage and we must receive your enrollment application within 60 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption.

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

Group Name \_\_\_\_\_ Group Number \_\_\_\_\_

Employer \_\_\_\_\_ Date            /            /

## 008803 (12-2003) / WAIVER OF COVERAGE

An Independent Licensee of the Blue Cross Blue Shield Association

**Prices effective April 1, 2006**  
**Blue Cross Blue Shield of Alaska**  
**Group 1011203**

**Monthly Premium**

<b>Full Time Employee</b>	<b>Employee Monthly premium</b>	<b>City</b>	<b>Total</b>
Employee	\$47.03	\$423.28	\$470.31
Employee & Spouse	\$88.23	\$794.11	\$882.34
Employee & Family	\$126.42	\$1,137.74	\$1,264.16
Employee & Child(ren)	\$85.21	\$766.92	\$852.13

## Health Insurance policy/plan general information and employee costs 2006

<b>Deductible</b>	In-Network	\$350
	Out-of-Network	Shared with In-Network Deductible
	Limits	Family Deductible 3x Individual - Fourth Quarter Carry-Over Excluded
<b>Office Visit Cost Share</b>	In-Network	\$25 copay
	Out-of-Network	MD/DO/DPM: 40%; Other Professionals: Same as In-Network Cost Share
	Limits	Unlimited
<b>Emergency Room Copay</b>	In-Network	\$75 then deductible & coinsurance
	Out-of-Network	\$75 then deductible & coinsurance
	Benefit Specification	Waive ER ded if direct admit
<b>Out of Pocket Maximum</b>	In-Network	\$1,850 individual (including ded) /\$5,550 family
	Out-of-Network	Not Applicable

<b>Dental Deductible</b>	In-Network	\$50
	Out-of-Network	\$50
	Limits	\$1,500 PCY
<b>Dental Preventive/Diagnostic</b>	In-Network	0%
	Out-of-Network	0%
	Limits	Roll to Dental limit
<b>Dental Basic</b>	In-Network	20%
	Out-of-Network	20%
	Limits	Roll to Dental limit
<b>Dental Major</b>	In-Network	50%
	Out-of-Network	50%
	Limits	Roll to Dental limit
<b>Orthodontia</b>	Limits	NA

<b>Pharmacy Benefit</b>	In-Network Retail	\$15/\$25/\$50
	In-Network Mail-order	\$37/\$62/\$125
	Out-of-Network	\$15/\$25/\$50 plus amount over allowable
	Limits	diabetic supplies covered; contraceptives covered
<b>Vision Exam</b>	In-Network	1 PCY
	Out-of-Network	1 PCY
	Limits	OV copay
<b>Vision Hardware</b>	In-Network	\$300 every 2 years
	Out-of-Network	\$300 every 2 years
	Limits	\$300 every 2 years

**Your next opportunity to change enrollment will be during the Open Enrollment period in March of every year, for an April 1<sup>st</sup> effective date**

**Please contact Human Resources for a plan booklet or if you have any questions. 747-1816**



**INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS  
\*\* CONTINUATION COVERAGE RIGHTS UNDER COBRA \*\***

**City and Borough of Sitka Benefits Plan**

To: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

**Introduction**

You are receiving this notice because you have recently become covered under the City and Borough of Sitka Benefits Plan (the Plan). The Plan has three group health components, Medical, Dental and Prescription Drug. This notice contains important information about your right to COBRA continuation coverage, which is temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the Plan (the Medical, Dental and Prescription Drug components) and not to any other benefits offered under the Plan or by the City and Borough of Sitka.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's summary plan description or contact the City and Borough of Sitka, which is the Plan Administrator. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

**What is COBRA coverage?**

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the City and Borough of Sitka, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

## **Who is Entitled to Elect COBRA?**

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of any employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminated your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under the Plan as a "dependent child".

## **When is COBRA Coverage Available?**

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the City and Borough of Sitka of any of these qualifying events.

## **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the City and Borough of Sitka in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you may obtain a copy of this form from the City and Borough of Sitka at no charge, or you can download the form at [www.cityofsitka.com](http://www.cityofsitka.com)), and you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided to the City and Borough of Sitka during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

## Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

## How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical and Dental components can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminated, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the maximum coverage periods described in this notice for several reasons, which are described in the Plan's summary plan description.

There are two ways (described in the following paragraphs) in which the period of COBRA coverage resulting for a termination of employment or reduction of hours can be extended.

### ***Disability extension of COBRA coverage.***

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the City and Borough of Sitka in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

**The disability extension is available only if you notify the City and Borough of Sitka in writing of the Social Security Administration's determination of disability within 60 days after the latest of:**

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

**You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from the City and Borough of Sitka at no charge, or you can download the form at [www.cityofsitka.com](http://www.cityofsitka.com)), and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures". If these procedures are not followed or if the notice provided to the City and Borough of Sitka during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

***Second qualifying event extension of COBRA coverage***

If your family experiences qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

**This extension due to a second qualifying event is available only if you notify the City and Borough of Sitka in writing of the second qualifying event within 60 days after the later of:**

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary) was still covered under the Plan).

**In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from the City and Borough of Sitka at no charge, or you can download the form at [www.cityofsitka.com](http://www.cityofsitka.com)), and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided to the City and Borough of Sitka during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

## **More Information About Individuals Who May Be Qualified Beneficiaries**

*Children born to or placed for adoption with the covered employee during COBRA coverage period*

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA lasts for other family members of the employee. To be enrolled in the Plan, the qualified child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age.)

### ***Alternate recipients under QMCSOs***

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the City and Borough of Sitka during the covered employee's period of employment with the City and Borough of Sitka is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

## **If You Have Questions**

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPPA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website)

## **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the City and Borough of Sitka informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the City and Borough of Sitka.

## **Plan Contact Information**

You may obtain information about the Plan and COBRA coverage on request from:

Mark Danielson  
Human Resources Director  
City and Borough of Sitka  
100 Lincoln St.  
Sitka, AK 99835  
(907) 747-1816  
[markd@cityofsitka.com](mailto:markd@cityofsitka.com)

This contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (if you do not have a copy, you may request one from the City and Borough of Sitka).

## Notice Procedures

**Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).**

**Notices Must Be Written and Submitted on Plan Forms:** Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this notice, and you may obtain copies from the City and Borough of Sitka without charge or download them at [www.cityofsitka.com](http://www.cityofsitka.com)). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

**How, When and Where to Send Notices:** You must mail or hand deliver your notice to:

Mark Danielson  
Human Resources Director  
City and Borough of Sitka  
100 Lincoln St.  
Sitka, AK 99835  
(907) 747-1816  
[markd@cityofsitka.com](mailto:markd@cityofsitka.com)

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from the City and Borough of Sitka).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage," and "Second qualifying event extension of COBRA coverage.")

**Information Required for All Notices:** Any notice you provide must include: (1) the name of the Plan (City and Borough of Sitka Benefits Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

**Additional Information Required for Notice of Qualifying Event:** If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the City and Borough of Sitka that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the City and Borough of Sitka that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

**Additional Information Required for Notice of Disability:** Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

**Additional Information Required for Notice of Second Qualifying Event:** Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

**Who May Provide Notices:** The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.



# City and Borough of Sitka

100 Lincoln St. Sitka Alaska 99835

## IMPORTANT INFORMATION ON THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This notice will provide you with information on the City and Borough of Sitka group health plan. Federal Law called HIPAA requires that you be notified of your right to enroll in the plan under a special enrollment provision if you acquire a new dependant, or you or eligible dependant decline coverage under this plan because of alternative coverage and later lose such coverage due to certain qualifying reasons. Second, this notice advises you of the plan's preexisting condition exclusion rules that may temporarily exclude coverage for certain conditions that you or our family may have.

### SPECIAL ENROLLMENT PROVISIONS

**Loss of coverage** – If you decline to enroll yourself or your dependants because of other health insurance coverage and that coverage terminates due to certain qualifying reasons, (i.e. exhaustion of COBRA or state law continuation rights; loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, or reduction in hours; or because employer contributions for other non-COBRA coverage ceases) you “may” in the future be able to enroll yourself or your dependants (whose coverage terminates for a qualifying reason) in this plan, provided that you request enrollment within 30 days after your other coverage ends, and that you meet certain other important conditions described in the Summary Plan Description.

**Marriage, Birth or Adoption** – If you acquire a new dependant as a result of a marriage, birth, adoption or placement for adoption, you “may” be able to enroll yourself, your spouse, and your newly acquired dependants, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, and that you meet certain other important conditions described in the Summary Plan Description.

If you decline enrollment for yourself or your dependants, you must complete a “Waiver” form. If you waive your right to enroll for yourself or your dependants and do not have other insurance coverage, you must wait until the plans next open enrollment period to enroll, except in cases of

marriage, birth, adoption, or placement for adoption. If you do enroll during the open enrollment period, you will be treated as a "late enrollee". The preexisting condition exclusion period that will apply to you and your dependants may be 18 months, not the normal 12 months, and can be reduced by creditable coverage under another plan. Please refer to the Summary Plan Description for the description of the late enrollee preexisting condition exclusion period.

## **PREEXISTING CONDITION PROVISION**

**Preexisting condition** - A condition (whether mental or physical) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received in the six (6) months prior to your "enrollment date." The waiting period for preexisting conditions is twelve months from your enrollment date. (Eighteen (18) months may apply for late enrollees.)

Prior periods of coverage may shorten or eliminate the plan's twelve-month preexisting condition exclusion period. You will be given credit for all days on which you had qualifying health care coverage prior to joining this plan. Prior days of coverage will reduce the twelve-month preexisting condition exclusion period, provided you did not have a sixty-three (63) day lapse in coverage after you creditable coverage ended. (Please refer to the Summary Plan Description, the lapse period with Blue Cross is 90 days).

A waiting period to get into the plan generally does not count as creditable coverage or as a lapse in coverage. Creditable coverage includes coverage under a group health plan, individual health insurance coverage, a State health benefits risk pool, Medicare, Medicaid, Military health coverage, Indian Health Service or tribal coverage, Federal or public health care plan, Peace Corps plan and certain other health care coverage.

## **CERTIFICATE OF CREDITABLE COVERAGE**

In order for the twelve-month preexisting condition exclusion period to be reduced, you must show that you had prior creditable coverage. You must provide a "**Certificate of Creditable Coverage**" from your prior plan. Most group plans, health insurers and HMO automatically furnish these certificates to individuals when coverage is lost. In addition all plans, insurers and HMOs are required to provide to certificates upon request. The certificate will state how long you had coverage under your prior plan and when it ended.

You have the right to request the certificate from your prior plan. Certificates of Creditable Coverage must be given to the plan administrator.

**WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE  
RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY**

On January 1, 1999, a new federal law, the Women's Health and Cancer Rights Act of 1998, became effective. This law requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

The law mandates that a participant who is receiving benefits, on or after the law's effective date for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage: all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema. This coverage will be provided in consultation with the patient and the patient's physician and will be subject to the annual deductible and coinsurance applicable under the plan. Please refer to the Summary Plan Description for more information.

**City and Borough of Sitka  
Human Resources  
100 Lincoln Street – Room 300  
747-1816**

# Group Insurance Enrollment Card

# LIFEWISE

**ASSURANCE COMPANY**

Life | Disability | Stop Loss

Please check appropriate box:  Transfer to another LifeWise Assurance Company division  
 New Hire     Rehire

GROUP NUMBER			DIVISION			SOCIAL SECURITY NUMBER			DATE OF BIRTH MM   DD   YYYY		
NAME: LAST			FIRST			MIDDLE			SEX <input type="checkbox"/> M <input type="checkbox"/> F		CLASS
EMPLOYMENT DATE MM   DD   YYYY		EFFECTIVE DATE MM   DD   YYYY		LTD EFF. DATE MM   DD   YYYY		Annual Salary _____ Supplemental Life Amt. _____					

I elect the following coverages from those for which I am eligible:

Basic Life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Accidental Death and Dismemberment (AD&D)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Supplemental Life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Short Term Disability (STD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dependent Life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Long Term Disability (LTD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

EMPLOYER (COMPANY NAME)	YOUR OCCUPATION
-------------------------	-----------------

BENEFICIARY NAME(S) \_\_\_\_\_  
(EXAMPLE: "HELEN LOUISE JONES" NOT "MRS. H.L. JONES")

RELATIONSHIP: \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_

In Community Property states, 50% of the payable benefit will be paid to the spouse unless the spouse signs a notarized statement waiving the right to the proceeds.

**SIGN ONE OPTION INDICATING EITHER YOUR ELECTION OR WAIVER OF BENEFITS:**

**ELECTION OPTION**

I request the Group Insurance for which I am entitled or for which I may become entitled under the provisions of the Group Policy or Policies issued by LIFEWISE ASSURANCE COMPANY, and I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this insurance.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
( MM / DD / YYYY )

**NOTE: Beneficiary designation is not valid unless card is dated and signed.**

**WAIVER OPTION**

I acknowledge that I have been offered Group Insurance under a Group Policy issued by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability, satisfactory to LIFEWISE ASSURANCE COMPANY, at my own expense if I should apply at a later date.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
( MM / DD / YYYY )

**Please keep original for your records** (to be submitted w/Life claim).

Routing: Original — Employer, Canary — LifeWise Assurance Company, Pink — Employee

Company Use Only		
	Employee	Spouse
Approved:	<input type="checkbox"/>	<input type="checkbox"/>
Declined:	<input type="checkbox"/>	<input type="checkbox"/>
Effective:	_____ / _____	
By:	_____ Date: _____	

LifeWise Assurance Company  
P.O. Box 2272, Seattle, WA 98111-2272



## Voluntary Life Insurance Enrollment Form

### PART A

Employee Name: Last _____ First _____ Middle _____			Birthdate: _____ / _____ / _____		Female: <input type="checkbox"/> Male: <input type="checkbox"/>
Coverage Amount Selected: <b>Employee Benefit:</b> \$ _____			<b>Spouse Benefit:</b> \$ _____		<b>Child Benefit:</b> \$ _____
			<input type="checkbox"/> Initial application <input type="checkbox"/> Increase in coverage		
Employer Name _____			Group Number _____		Division: _____
EMPLOYEE Home Address: _____					Social Security Number: _____
Employee Occupation: _____			Date of Hire: _____		Work Hours per Week: _____
Spouse Name: Last _____ First _____ Middle _____			Birthdate: _____ / _____ / _____		Social Security Number: _____
Beneficiary for Employee Coverage/Relationship: <small>(Employee is beneficiary for spouse coverage.)</small>			Mailing Address: _____		
Name _____ / _____ Relationship _____					
Attach a separate sheet if more space is required. In Community Property states, 50% of the payable benefit will be paid to the spouse unless the spouse signs a notarized statement waiving the rights to these proceeds.					
I hereby apply for voluntary life insurance under the provisions of the Group Policy for which I am eligible and authorize deductions from my wages to cover the cost of the insurance.					
Date: _____ / _____ / _____ Signature: _____					

**IF YOU ARE DECLINING COVERAGE, YOU MUST SIGN BELOW AND RETURN THIS FORM TO YOUR EMPLOYER. DO NOT COMPLETE PART B.**

**WAIVER OPTION**

I acknowledge that I have been offered Voluntary Life Insurance issued by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to LifeWise Assurance Company, at my own expense, if I should apply at a later date.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Employee retain bottom copy. Return remaining copies to LifeWise Assurance Company

### PART B

This section to be completed only if requesting amounts over the Guarantee Issue Amount, requesting an increase in insurance, or if you are a late enrollee. If you are declining coverage, do not complete this section.

Name and address of the Doctor or facility that has your medical records: _____		Employee's Doctor: _____		Spouse's Doctor: _____	
Address: _____		Address: _____		Address: _____	
Employee: Height: _____ Weight: _____		Spouse: Height: _____ Weight: _____			
Have you gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds. <small>(Explain)</small>		Have you gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds. <small>(Explain)</small>			
Annual Salary: \$ _____					

**Check yes or no** for each of these questions and give details for any "yes" answers after Item #5. Attach a separate sheet if more space is required.

	Employee		Spouse		
	YES	NO	YES	NO	
1. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you now under regular medical observation or taking medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Within the last five years, have you consulted a physician for any disease or injury, or have you had or been advised to have any surgical operation or diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. To the best of your knowledge, have you had or been told you had an Immune Deficiency Disorder (AIDS), or the AIDS Related Complex (ARC), or tests results indicating exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. <b>Please check either "yes" or "no" if you or your spouse ever had or been told that you had any of the following. (Indicate if applicable to you or your spouse.)</b>					
	YES	NO	YES	NO	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, Albumin or Sugar in the Urine	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Disorder of the stomach, intestines or liver	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis or Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumors	<input type="checkbox"/>	<input type="checkbox"/>
			Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>

EE or Sp	CONDITION	DATE	REMAINING EFFECTS	PHYSICIAN'S FULL NAME AND ADDRESS

I have read the statements on this application and agree that the above answers are complete and true to the best of my knowledge and belief. I acknowledge receipt and understanding of the "Notice of Exchange of Information" explained on the back of this form. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give LifeWise Assurance Company or its reinsurers any such information. A photographic copy of this authorization shall be valid as the original.

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Spouse Signature (if applying for coverage) \_\_\_\_\_

## NOTICE OF EXCHANGE OF INFORMATION

Thank you for enrolling for Voluntary Group Life Insurance with LifeWise Assurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. LifeWise Assurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit organization of life insurance companies which operates as information exchange in behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston Massachusetts 02112, telephone number (617) 426-3660.

LifeWise Assurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

## BENEFICIARY DESIGNATION OR CHANGE AUTHORIZATION

### INSTRUCTIONS FOR EMPLOYER:

- 1) Please verify that all spaces are completed in full.
- 2) Please validate this card once the beneficiary change is completed.
- 3) **Please keep this card with the original enrollment record in the employer's personnel file (to be submitted with life claim).**
- 4) Questions should be referred to LifeWise Assurance Company

Subject to the terms of my Group Insurance Policy, I hereby designate or amend and revoke any former beneficiary named by me, and I now designate as Beneficiary:

NAME (Last, First, Middle Initial)	RELATIONSHIP
ADDRESS (Street, City, State, Zip)	
NAME (Last, First, Middle Initial)	RELATIONSHIP
ADDRESS (Street, City, State, ZIP)	

If two beneficiaries are to share jointly, the last name entered should be followed by the words, "equally or to the survivor," if three or more beneficiaries are to share jointly the last name entered should be followed by the words "the survivor or survivors equally." If the interest of one beneficiary is to be contingent to the interest of another, after the name of the first beneficiary the following words should be placed, "if living, otherwise to."

In Community Property states, 50% of the payable benefits will be paid to the spouse unless the spouse signs a statement waiving the right to the proceeds.

All information not already given as to the full name, and relationship of the proposed beneficiary should be filled in. If the proposed beneficiary is a married woman, her own given names must be furnished, not those of her husband.

Example: "Jones, Helen Louise" - not "Mrs. H.L. Jones")

EMPLOYEE SIGNATURE	DATE / /
EMPLOYEE NAME (Please Print)	
GROUP POLICY NUMBER	EMPLOYEE SOCIAL SECURITY NUMBER

**SUPPLEMENTAL BENEFITS SYSTEM  
POLITICAL SUBDIVISIONS  
ENROLLMENT WORKSHEET  
Personal Information**

Name:	Date of Birth:
Social Security Number:	Monthly Base Wage:
Date of Hire/Qualified Status Change (mm/dd/yy):	

<b>ENROLLMENT REASON</b>	<b>PHONE SYSTEM CODE</b>
<input type="checkbox"/> New Hire	1
<input type="checkbox"/> Rehire	13
<input type="checkbox"/> New Child – Birth or Adoption*	2
<input type="checkbox"/> Death of Dependent*	3
<input type="checkbox"/> Change in Marital Status*	4
<input type="checkbox"/> Child No Longer Eligible for Benefit Coverage*	5
<input type="checkbox"/> Spouse Begins/Ends Employment*	6
<input type="checkbox"/> Spouse Change From/To Full-Time/Part-Time*	15
<input type="checkbox"/> Member Change From/To Full-Time/Part-Time*	14
<input type="checkbox"/> Spouse Begins Extended Unpaid Leave*	9
<input type="checkbox"/> Health Coverage Change Due to Bargaining Unit Change*	10
<input type="checkbox"/> Short-Term Nonpermanent From/To Long-Term Nonpermanent/Permanent*	11

<b>BENEFIT PLAN</b>	
	<b>Phone System Code</b>
Political Subdivisions Benefit Plan	3

**\*Qualified Status Changes.** If you do not have your Personal Identification Number (PIN), please contact the Benefits Section at (907) 465-8600.

# SUPPLEMENTAL BENEFITS SYSTEM ENROLLMENT WORKSHEET

**PLEASE KEEP FOR YOUR RECORDS**

Use this worksheet to record your elections before enrolling. Price tags are your monthly costs for coverage; use the enclosed premium sheet to calculate your premiums. You can enroll any time, day or night, **up to 30 days from your hire date or status change**, by accessing our internet site at [www.state.ak.us/drb](http://www.state.ak.us/drb) or our telephone system at 1-888-AKBENES (1-888-252-3637) or in Juneau at 465-5050.

**LIFE INSURANCE**

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag for Employee</u>	<u>Option Code:</u> _____
0	No Coverage		
1	\$10,000	SEE	
2	\$20,000	PREMIUM	
3	\$30,000	CARD	
4	\$40,000		<i>Price Tag:</i> \$ _____
5	\$48,000		

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag</u>	<u>Option Code:</u> _____
0	No Coverage	\$0.00	
1	Employee Only	\$4.00	
2	Employee and Family	\$6.00	<i>Price Tag:</i> \$ _____

*AD&D is available only if you have elected at least \$10,000 of life insurance coverage.*

**SURVIVOR BENEFITS**

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag for Employee</u>	<u>Option Code:</u> _____
0	No Coverage		
1	5 Years at \$765/Month		
2	10 Years at \$455/Month	SEE	
3	15 Years at \$360/Month	PREMIUM	
4	20 Years at \$315/Month	CARD	
5	25 Years at \$290/Month		<i>Price Tag:</i> \$ _____
6	30 Years at \$275/Month		

*Survivor Benefits are not available if you have elected more than \$10,000 of life insurance coverage.*

**SHORT-TERM DISABILITY INSURANCE**

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag for Employee</u>	<u>Option Code:</u> _____
0	No Coverage	\$0.00	
1	Plan A	\$1.96	<i>Price Tag:</i> \$ _____

**LONG-TERM DISABILITY INSURANCE**

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag for Employee</u>	<u>Option Code:</u> _____
0	No Coverage	SEE	
1	Plan B - 50%	PREMIUM	
2	Plan C - 70%	CARD	<i>Price Tag:</i> \$ _____

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**DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT (DCRA)**

<u>Code</u>	<u>Option</u>	<u>Monthly Contribution/Price Tag</u>
0	No Participation Participation	(min:\$25/month, max:\$5,000/calendar year) Price Tag: \$ _____

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Enter the total of your monthly Price Tags: \$ \_\_\_\_\_

The total price tag will be split and deducted from your pay on a pretax basis.

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By contacting the automated enrollment system and using your PIN to enroll, you certify that you have received and read the plan provisions, you understand you cannot change your elections, except as allowed by plan provisions, and your elections authorize the State of Alaska to make any required adjustments to your pay.

**STATE OF ALASKA  
SUPPLEMENTAL BENEFITS SYSTEM  
2006/2007 PREMIUM CARD**

*The monthly premiums for each option is listed below. The premium cost for each benefit follows. The total premium cost for the options you select will be withheld from your salary each month. The premiums will be split. Since these premiums are deducted before taxes are calculated, your taxable income is reduced. The premiums on this card are effective 7/1/2006 through 6/30/2007.*

**LIFE INSURANCE**

Employee Age	Monthly Cost				
	\$10,000	\$20,000	\$30,000	\$40,000	\$48,000
Under 30	\$ .90	\$ 1.80	\$ 2.70	\$ 3.60	\$ 4.32
30 - 39	1.10	2.20	3.30	4.40	5.28
40 - 44	1.80	3.60	5.40	7.20	8.64
45 - 49	2.60	5.20	7.80	10.40	12.48
50 - 54	4.10	8.20	12.30	16.40	19.68
55 - 59	6.10	12.20	18.30	24.40	29.28
60 - 64	8.70	17.40	26.10	34.80	41.76
65 - 69	12.60	25.20	37.80	50.40	60.48
70 - 74	27.90	55.80	83.70	111.60	133.92
75 - 79	53.00	106.00	159.00	212.00	254.40
80 - 84	75.20	150.40	225.60	300.80	360.96
85 and over	115.70	231.40	347.10	462.80	555.36

To determine your monthly premium, find your age as of 7/1/2006, the amount of life insurance elected, and the corresponding premium on the chart.

**ACCIDENTAL DEATH AND DISMEMBERMENT**

Who is covered	Monthly Cost
Employee	\$4.00
Employee and Family	\$6.00

Your monthly premium is based on whom you elect to cover: you or you and your family.

**SURVIVOR BENEFITS**

Employee Age	Monthly Cost
Under 30	\$3.04
30 - 39	3.80
40 - 44	6.08
45 - 49	8.74
50 - 54	13.68
55 - 59	20.52
60 - 64	29.64
65 and over	42.56

To determine your monthly premium, find your age as of 7/1/2006 and the corresponding premium on the chart.

**SHORT-TERM DISABILITY**

Who is covered	Plan	Monthly Cost
Employee	Plan A \$210/week	\$1.96

Every employee who elects this benefit pays the same premium.

**LONG-TERM DISABILITY**

Employee Age	Premiums per \$100 of Wage	
	Plan B (50%)	Plan C (70%)
Under 25	\$ .65	\$ 1.45
25 - 29	.66	1.46
30 - 34	.67	1.48
35 - 39	.69	1.53
40 - 44	.74	1.61
45 - 49	.79	1.72
50 - 54	.86	1.88
55 - 59	.95	2.05
60 - 64	.97	2.10
65 - 69	1.01	2.19
70 and over	1.25	2.62

To determine your monthly premium, divide your monthly wage by 100 and multiply the result by the monthly premium for your age group. Example: If your base pay is \$2,000 monthly and you are 54, the cost for Plan B is \$17.20 per month (2,000 ÷ 100 = 20 x \$.86 = \$17.20).

**DEPENDENT CARE ASSISTANCE PLAN**

Minimum Monthly Amount	\$ 25
Maximum Annual Amount	\$5,000

You must contribute in whole dollar amounts. The amount of contributions you elect will be deducted from your paycheck in equal amounts throughout the year.



# General Plan Information

## Investment Option Detail Sheets with Fund Information

*Fund descriptions and the fund's top ten holdings are updated approximately every 6 months. Fund return results are reported quarterly and are included with participant account statements.*

For more detailed information on available investment options, please visit our Web site at [www.state.ak.us/drj](http://www.state.ak.us/drj). Under "Programs", click in the Supplemental Annuity Plan" line, then on the next page, under "Publications" click on "Investment Option Detail Sheets". Please Note: Adobe Acrobat Reader is required to download and view Investment Option Detail Sheets. You can print a copy of any sheet directly from your Web browser; if you are unable to do so, please call DRB.

## What is the Alaska Supplemental Annuity Plan?

The Alaska Supplemental Annuity Plan (SBS-AP) is a defined contribution plan governed by section 401(a) of the Internal Revenue Code. A portion of your wages and a matching employer contribution are made pre-tax to this plan instead of contributions to Social Security. These contributions plus any change in value (interest, gains and losses), is payable to you or your beneficiary at a future date.

## How are contributions determined?

Your SBS-AP account is credited with a gross contribution that consists of a reduction to your wages of 6.13% and a matching employer contribution of 6.13%. The total contribution is 12.26% of your payroll up to the current social security maximum wage base. This wage base changes yearly. Your personnel department or plan representative can tell you the current wage base in effect.

## How is the money invested?

SBS Annuity is a participant-directed plan. This means that you choose from the investment options offered by the plan. The providers of these investment options were selected by the Alaska State Pension Investment Board. Investment options are described in detail in the Plan Information Booklet, individual Investment Option Detail Sheets which are available on the Division's Web site, and in a quarterly report that is mailed with your statement.

## What are my investment options?

- Brandes Institutional International Equity Fund
- T. Rowe Price Small-Cap Stock Trust
- Citizens Core Growth Fund
- S&P 500 Stock Index Fund
- Global Balanced Fund
- Tactical Asset Allocation Fund
- Alaska Long-Term Balanced Fund
- Alaska Balanced Fund
- Daily Gov't/Corp. Bond Fund
- Short-Term Investment Fund
- Alaska Target 2020 Fund
- Alaska Target 2015 Fund
- Alaska Target 2010 Fund
- Alaska Target 2005 Fund

## What if I need to make investment changes?

You may make transfers among existing fund options and changes for allocating future contributions once a day. There is no extra charge for daily changes. Changes may be made by telephone via KeyTalk® or a client service representative, the Internet, or in writing.

## What are the plan expenses?

There are no front-end loads for investment. Expenses are charged to your account in order to cover the cost of administration of the plan. There are two types of fees: Monthly—0.09% annual rate on assets (0.0009 / 12 x month-end asset balance) plus, a fixed annual fee of \$35 for actively contributing participants or \$25 for non-contributing members.

In addition, the funds have annual investment expenses which vary depending upon the fund you choose. The returns are net of these costs. For detailed information, please read the corresponding Investment Option Detail Sheet and the quarterly report that is mailed with your statement.

## When can I make a withdrawal?

You are first eligible to receive payment of your account 60 days after you have been terminated from employment. If you are re-hired before the 60-day period has passed, the withdrawal request will be canceled and a new 60-day period will begin at the next termination. Actual payment mailing occurs after you have been terminated 60 days.

The only exception to payment eligibility earlier than 60-days after termination is for a qualified hardship. There are very strict criteria that must be met for a hardship distribution.

## What are the plan payment options?

When you terminate, your account value may be applied to the settlement option you choose.

These options include:

- Lump sum payment
- 5, 10 & 15 year period certain annuity
- Single life annuity
- Single life annuity with 10 or 15 year certain
- 50% or 100% Joint/Survivor annuity
- Direct Transfer to an IRA or other qualified plan

*continued* ►

# General Plan Information

## Alaska Supplemental Annuity Plan

### Plan Benefits, Continued

Lump-sum payments to participants, former spouse alternate payees, and spouse beneficiaries are eligible for direct transfer or rollover to *non*-Roth IRAs. Payments can NOT be directly transferred or rolled over to Roth IRAs.

A rollover is a payment of your plan benefits to your individual retirement account (IRA) or to another employer plan. A payment from the plan that is eligible for “rollover” can be taken in two ways: you can have your payment paid in a direct rollover or paid to you.

### Taxation

The amount of taxes you pay, and when you pay them are determined by whether you take payment directly or make a direct transfer to an IRA or other qualified plan. Your payment will be taxed in the current year unless you roll it over. You may be able to use special tax rules that could reduce the tax you owe. However, if you receive the payment before age 59½, you also may have to pay an additional 10% tax penalty.

Under the State Taxation of Pension Income Act of 1995, monies from plans such as SBS Annuity are also taxed using the state of the recipient’s residence. States with such mandatory withholding, at varying rates include: California, Delaware, Georgia, Hawaii, Iowa, Kansas, Maine, Massachusetts, North Carolina, Oklahoma, Oregon, Vermont and Virginia.

### KeyTalk®

KeyTalk® is a toll-free touch-tone service that allows you access 7 days a week, 24 hours a day (except between 10:00 p.m. Saturday and 10:00 a.m. Sunday, Alaska time) to:

- Obtain your current account balance
- Obtain daily fund values
- Transfer funds from one investment option to another without submitting forms. Written confirmation of all transfers will be sent.
- Change allocations of future deposits without submitting forms. Written confirmation of all changes will be sent.

To utilize KeyTalk®, you will need a Personal Identification Number (PIN). This will be assigned to you upon enrollment. The KeyTalk® phone number is **1-800-701-TALK (1-800-701-8255)**.

If you wish to speak to a client service representative between 3:00 p.m. and 5:30 p.m., Alaska time, Monday through Friday, and you are either a rotary-dialer *or* you are a touch-tone dialer without a PIN, please use the following number: 1-800-232-0859.

### Internet Access

You can also use the Internet to conduct the same transactions you can do through KeyTalk®. You can do this by going to the Division of Retirement and Benefits homepage at **www.state.ak.us/drb**. Under “Programs”, select “Supplemental Annuity Plan”.

### Toll-free Great-West Retirement Services<sup>SM</sup> Client Services Line

If you do not have access to a touch-tone phone and want to make changes or obtain any of the information listed above, call KeyTalk®, remain on the line and you will be transferred to a Great-West Retirement Services<sup>SM</sup> client service representative. Client service representatives are available to assist you Monday - Friday, 6:00 a.m. to 5:30 p.m. Alaska time. If you wish to speak to a client service representative between 3:00 p.m. and 5:30 p.m., Alaska time, Monday through Friday, please use the following number: 1-800-232-0859. You may also call DRB in Juneau at 1-800-821-2251 or 465-4460 from Juneau with any questions about the Plan.

### TDD Line (Telecommunication Device for the Deaf)

Also, for hearing-impaired participants, a special toll-free TDD (Telecommunication Device for the Deaf) number is available which allows participants to communicate with client service representatives. The TDD line is available Monday - Friday, 6:00 AM to 5:30 PM Alaska time. This number is 1-800-766-4952.

### Transactions Required through Juneau DRB

The following transactions must be conducted through the Juneau DRB (Division of Retirement and Benefits) office:

- Arranging for withdrawal of your funds
- Changing your address, phone number, name, etc.

To contact the Juneau DRB office, call 1-800-821-2251 or 465-4460 from Juneau.

### Statements

You will receive a comprehensive statement of your account each quarter.

*Registration with the Securities and Exchange Commission is not required for the State of Alaska Supplemental Annuity Plan.*



### Section III. Consent to Beneficiary Designation

#### INSTRUCTIONS

If you are *MARRIED*, your spouse is automatically your 100% primary beneficiary unless he or she consents to another beneficiary. Your spouse's written consent may be waived if:

- you were not married to your spouse during any part of your PERS or TRS employment;
- you have been married for less than two years and you have established that you and your spouse are not living together; or
- your spouse cannot be located.

Your spouse may waive entitlement to benefits by completing and signing the "*Spouse's Consent*" below before a notary public or other authorized person.

If you are a *SINGLE PARENT*, there are death benefits that may be payable to your dependent child if you die before retirement. **These benefits are only payable to your children if they are your designated beneficiaries.** Because benefits cannot be paid directly to minor children, they will be paid to the children's parent or legal guardian, unless you establish a trust and designate the trust as beneficiary for your children. You should NOT designate another person as beneficiary to receive your children's benefits. Benefits payable to TRS survivors under the 1% Supplemental Contributions provision will be paid in accordance with Alaska Statutes 14.25.162-164.

#### SPOUSE'S CONSENT

I, \_\_\_\_\_, am the spouse of \_\_\_\_\_.

I understand that I am entitled to the death benefits that will be paid if my spouse dies. I have reviewed the *occupational* and *nonoccupational death provisions* described in the *PERS and TRS Information Handbooks*. I understand that, depending upon the circumstances of my spouse's death, I may be eligible to receive either a lump sum benefit or monthly benefits for the rest of my life and that major medical insurance will be available to me and my eligible dependents while I am receiving monthly benefits.

By signing this consent, I agree to waive my right to any benefits that would be paid to me and consent to the naming of another beneficiary.

**Your signature must be witnessed below**

Signature

Date

**Signature witnessed by:**

\_\_\_\_\_  
Plan Representative (Must be a designated employee  
of the Division of Retirement and Benefits)

or

\_\_\_\_\_  
Notary Public or Postmaster

State of \_\_\_\_\_

My Commission Expires: \_\_\_\_\_