Alyeska pipeline SERVICE COMPANY

Benefit Enrollment/Change Form

Employee ID:	Employee Name: (Last, First, M.I.)	Social Security Number:

Reason for completing form: ☐ *New Hire/Rehire ☐ *Birth/Adoption ☐ *Dependent Ineligible ☐ Open Enrollment ☐ *Marriage/Domestic Partner ☐ *Divorce/Dissolution ☐ Other:_____

*All Life Events have a 30-day deadline for enrollments/changes – see back of form

Event Date: _____

Employee and Eligible Dependent Information (enter **Employee** information on the first line than eligible dependents)

Name (Last, First, M.I.)	Relationship	SSN	Birth Date	Gender	Medical Plan		Dental Plan		HR use
					Add	Drop	Add	Drop	
	SELF				☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
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					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐

MEDICAL PLAN (includes vision)

☐ Employee only
☐ Employee + 1 (spouse or child)
☐ Employee + 2 or more dependents (family)
☐ Employee + domestic partner**
☐ Employee + child(ren)+ domestic partner**

-or-

☐ I do not want MEDICAL PLAN COVERAGE

DENTAL PLAN

☐ Employee only
☐ Employee + 1 (spouse or child)
☐ Employee + 2 or more dependents (family)
☐ Employee + domestic partner**
☐ Employee + child(ren) + domestic partner**

-or-

☐ I do not want DENTAL PLAN COVERAGE

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

This account uses pre-tax payroll deductions to pay for eligible health, dental, vision and hearing expenses not covered by any benefit plan in which enrolled. Min $120; Max $3,200 for the 2024 coverage period. See page 2 of this form.

☐ Annual coverage period goal amount: $_____ ☐ I do not want a HEALTH CARE FSA

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

This account uses pre-tax payroll deductions to pay for eligible child/elder (DAYCARE) care expenses of your eligible dependents. Min $120; Max $5,000, per family or $2,500 if married and filing a separate tax return.
This account is NOT for reimbursement of medical expenses. See page 2 back of this form.

☐ Annual coverage period goal amount: $_____ ☐ I do not want a DEPENDENT CARE FSA

I certify that the above information is correct and authorize my employer to make (or change) applicable deductions from my salary.	
Employee Signature:	Date:
Benefits Representative Review:	Date:
Input by/date:	Verified by/date:

Scan copy to: CompensationBenefits@alyeska-pipeline.com
Employee may keep original upon confirmed confirmation of receipt

Employee ID

Employee six-digit ID number.

Employee Name

Employee's full legal name.

Social Security Number

Employee's nine-digit Social Security number.

Employee and Dependent Information:

Enter employee (self) on first line. Enter dependent(s) name. Your dependents include your spouse/domestic partner and your child(ren) up to the age 26.

Disabled dependent: Coverage may be continued beyond age 26 for child(ren) who are physically or mentally disabled and covered under the plan. Contact health plan administrator for the Request for Certification of Disabled Dependent form.

**Affidavit of Domestic Partnership (TAPS DOC 10499) must meet criteria listed have affidavit signed with a notary. The date of the signed/notarized affidavit is the event date. This completed form must be provided with affidavit within 30 days of event date.

*Newborn/Adopted child: An eligible child will be covered for the first 30 days following birth. If continued coverage is desired this completed enrollment form must be received by HR within 30 days from birthdate. Adoptive dependent children, including children acquired through legal guardianship, can also be added to the plan with a completed enrollment form received by HR within 30 days from the child's date of adoption or placement for adoption. SSN can be updated later if not available when completing form.

Important reminder:
You must remove any ineligible dependent from your coverage. Failure to do so may result in Premera Blue Cross Blue Shield of Alaska recovering paid healthcare claims from you for the ineligible dependent during which time they cease to be eligible for coverage. See dependent eligibility in the applicable summary plan description on the A-NET or the External Benefit website at Employees and Retirees - Alyeska Pipeline (alyeska-pipe.com).

Relationship:

Enter relationship of dependent to employee:

Self
Spouse
Domestic Partner (taxable) – TAPS document #10499 Affidavit of Domestic Partnership required
Child / Adopted child
Legal guardian

SSN – Dependents

For new dependents, please include SSN.

Birth Date – Dependents

Month/Day/Year

Gender - Dependents

F = Female, M = Male

Medical Insurance Plan:

Mark an "X" in the appropriate box for coverage level elected.

Dental Insurance Plan:

Mark an "X" in the appropriate box coverage level elected.

Flexible Spending Account (Health Care and/or Dependent Care):

Any amount remaining in my **Flexible Spending Account (FSA)** not used for eligible expenses incurred during the coverage period (first day of March – last day of February) will be forfeited in accordance with current plan document provisions and tax laws. Alyeska's FSA does not rollover. In the event employment ends with Alyeska and the person is later re-hired in the same coverage period, they must make the same elections as before separation from employment to re-enroll in this plan. By electing you authorize and direct Alyeska to reduce my salary in the amount necessary to pay for benefit annual goal for the Coverage Period of March 1 through the last day of February. FSA deductions taken during a calendar year will affect W-2 reporting for that calendar year. FSA administered by Peak One Administration. Contact Peak One at 1-866-315-1777 for questions regarding FSA eligible expenses and claim process.