

November 6, 2006

Dear Select Benefits Participant:

Please read this letter to determine if this mailing applies to you. By order of the Supreme Court and under regulations (2 AAC 38) adopted by the Commissioner of the Department of Administration, the State of Alaska will offer same-sex partner benefits effective January 1, 2007. The Division of Retirement and Benefits is conducting a *special enrollment* to allow you to enroll an eligible same-sex partner and eligible children of your same-sex partner in health insurance coverage if you choose to do so. You have received this packet because you have not enrolled a spouse under your active health insurance plan.

The special enrollment period begins November 20, 2006 and ends December 8, 2006, at 5:00 p.m. Alaska Time. In order to be a valid enrollment, a Same-Sex Partner Affidavit, Health Dependent Enrollment, and the Select Benefits Same-Sex Partner Special Enrollment forms must be received by the Division of Retirement and Benefits, or the forms must be postmarked, **by December 8, 2006**. All other documentation may be submitted at a later date. This is a *special enrollment only*. If you are not enrolling a same-sex partner and/or children of your same-sex partner, you **cannot** change your elections at this time.

It is possible that litigation could result in a change to the eligibility criteria outlined in the enclosed enrollment guide and the regulations which are contained in the back of the enrollment guide. The regulations under which this enrollment is conducted have been submitted to the Lt. Governor's Office for filing. They will become effective 30 days after the Lt. Governor signs and files the regulations. The Division of Retirement and Benefits will notify participants if any changes to the criteria are made.

If you do choose to enroll a same-sex partner and/or children of your same-sex partner, please read the enrollment guide carefully. The guide contains important information about tax implications that you should understand. Once you have read the guide, if you have any questions, please contact the Division of Retirement and Benefits at the numbers and addresses provided on the back of the enrollment guide.

Sincerely,



Scott J. Nordstrand
Commissioner

SJN/TC/cmK

Enclosure

SB

cc: Division of Retirement and Benefits



State of Alaska

Division of Retirement and Benefits

Select Benefits Special Enrollment Guide

ONLY MEMBERS WHO ARE ENROLLING SAME-SEX PARTNERS CAN CHANGE THEIR ELECTIONS!

What's In This Enrollment Guide

Effective January 1, 2007, the State of Alaska's Health Plans will offer same-sex partner benefits. This special enrollment is specifically for members to enroll their same-sex partners and eligible dependent children of same-sex partners who qualify under 2 AAC 38. It is possible that litigation could result in a change to the eligibility criteria.

This guide gives you the information you need to make *Select Benefits* special enrollment decisions for the remainder of fiscal year 2007 (January through June). It provides information about the choices available to you, details on the costs of coverage and how to enroll during this special enrollment for members with same-sex partners. The special enrollment period begins **November 20, 2006, and ends December 8, 2006, at 5:00 p.m. Alaska Time.**

This guide includes a Same-sex Partner Affidavit, Dependent Enrollment forms, and a Dependent Documentation matrix describing the documents required by the plan to prove eligibility of those you enroll. See page 18 for a list of dependents who are eligible for coverage. A Declaration of Tax Status form is included and must be completed for each dependent enrolled.

A same-sex partner who qualifies under 2 AAC 38 will be treated as a spousal dependent whom an employee may designate to receive survivor/death benefits from the Public Employees' Retirement System, Teachers' Retirement System, Judicial Retirement System, and Elected Public Officers Retirement System.

Additional forms for designations of beneficiaries to receive the Alaska Supplemental Annuity Plan account, Alaska Deferred Compensation Plan account, Basic and Optional Life insurance benefits, and payment of Unpaid Compensation upon the death of an employee are also included in this packet for your convenience. Beneficiary forms are also available on our website at www.state.ak.us/dr/b, under Forms. These forms are not subject to the deadlines of the special enrollment, and may be filed by an employee at any time. Some of these beneficiary forms can be used to meet documentation requirements for enrollment of a same-sex partner. Beneficiary designations are not valid until on file with the division.

Please read the instructions carefully as you enroll your same-sex partner and any eligible dependent children. As this is a **special enrollment only**, website and telephonic enrollment is not available, **paper enrollment is required.**

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IMPORTANT TAX IMPLICATIONS

You and the State share the cost of covering an eligible same-sex partner and eligible dependent children—the State pays for coverage under the Economy medical plan and Preventive dental plan. You pay for additional coverage under the Standard and Premium plans. However, there are additional financial and tax implications to consider. The Internal Revenue Service (IRS) has determined that the cost of providing benefits for same-sex partners and their children who do not meet the IRC Section 152 (as modified by IRC Section 105(b)) definition of qualified dependents is considered ordinary or “imputed income” and is, therefore, subject to taxes.

If a covered same-sex partner or same-sex partner’s child is not an eligible “dependent” of the employee under federal tax law, the State must report the fair market value (FMV) of the employee’s same-sex partner/child benefits as wages or “imputed income” to the IRS, resulting in increased taxable gross income for federal income taxes as well as Medicare taxes withheld from the employee’s paycheck. In that case, the cost to the employee of obtaining benefits for a same-sex partner and/or child of a same-sex partner is actually more than just the cost of the employee’s required premium. In fact, there will be some cost to the employee of obtaining benefits for a same-sex partner even under the Economy medical plan and Preventive dental plan.

Imputed income attributable to you for your same-sex partner and/or your eligible children’s coverage will be reported on your payroll warrant for tax purposes. This amount represents the cost of providing benefits for your same-sex partner and/or their eligible children so that required taxes on the imputed income will be

deducted from your paycheck. Note that Alaska SBS employer and employee contributions do not apply to imputed income.

Because the child of a same-sex partner must be financially dependent on you to be eligible for coverage under the Select Benefits plan, in most situations a child of a same-sex partner who is eligible for coverage under the Select Benefits plan will also be a dependent of the employee under federal tax law, and no income will be imputed to you for coverage of the child for federal tax purposes. If, however, the child is eligible for coverage but does not qualify as a dependent under federal tax law, imputed income would be attributable to you for that child’s coverage.

The following table shows the amount of income that will be imputed each month based on benefit plan elections made during this special enrollment for the first half of 2007. The amounts change July 1, 2007, when new contribution rates go into effect. In most circumstances federal income tax and Medicare taxes equal to 1.5% of the imputed amounts shown will be withheld. The actual amount of income tax withheld depends on your pay and the amount of allowances you claim on Form W-4. Imputed income amounts are included for coverage of children of a same-sex partner, in the unusual event that the covered child is not a “dependent” for federal tax purposes.

Fair Market Value for Non-Tax Qualifying Dependents (These numbers do NOT represent the tax you will pay)

Medical & Rx Coverage Level

FY 2007 Monthly Imputed Income - Medical & Rx

	EE+Same-sex Partner Who Is Not EE's Tax Dependent	EE+Same-sex Partner Child Who Is Not EE's Tax Dependent	Family (EE+ Same-sex Partner +Same-sex Partner Child Who Are Not EE's Tax Dependents)
Prem EE / Std FAM	\$ 470	\$ 282	\$ 752
Premium Family	\$ 605	\$ 363	\$ 968
Standard	\$ 470	\$ 282	\$ 752
Economy	\$ 405	\$ 243	\$ 648

Dental Coverage Level

FY 2007 Monthly Imputed Income - Dental

	EE+Same-sex Partner Who Is Not EE's Tax Dependent	EE+Same-sex Partner Child Who Is Not EE's Tax Dependent	Family (EE+ Same-sex Partner +Same-sex Partner Child Who Are Not EE's Tax Dependents)
Premium	\$ 74	\$ 107	\$ 181
Standard	\$ 44	\$ 64	\$ 108
Preventative	\$ 19	\$ 28	\$ 47

**Vision
Coverage Level**

**FY 2007 Monthly Imputed
Income - Vision**

	EE+Same-sex Partner Who Is Not EE's Tax Dependent	EE+Same-sex Partner Child Who Is Not EE's Tax Dependent	Family (EE+ Same-sex Partner +Same-sex Partner Child Who Are Not EE's Tax Dependents)
No Coverage	-	-	-
Standard	\$ 17	\$ 14	\$ 31
Managed	\$ 11	\$ 9	\$ 20

An Exception to the Rule: *Dependents for Federal Income Tax Purposes*

If your same-sex partner and eligible dependent children qualify as your dependents under IRC Section 152 (as modified by IRC Section 105(b)), the cost for their benefits is not considered taxable income to you. Generally, to qualify as an IRC Section 152 dependent (as modified by IRC Section 105(b)) of an employee during a given tax year, the same-sex partner and same-sex partner's children must be a "qualifying relative" of the employee. To be a "qualifying relative," the same-sex partner and/or the children of the same-sex partner must meet the following requirements:

1. Have the same principal place of abode as the employee for the full tax year (January 1 through December 31), except for temporary absences such as vacation, military service, or education. If the partnership dissolves other than on December 31, for reasons other than the death of the same-sex partner, the tax exclusion is lost for the entire year. If the relationship terminates due to the death of the partner, the partner would continue to be treated as a dependent for the entire tax year;
2. Receive more than half of his or her support from you, the employee;
3. Be a U.S. citizen, U.S. national, or a resident of U.S., Canada, or Mexico; and,
4. Not be anyone else's "qualifying child" under Code Section 152.

Whether or not you will be claiming your same-sex partner and/or partner's dependent children as tax dependents for insurance purposes under IRC Section 152 (as modified by IRC Section 105(b)) you must

complete and sign the Declaration of Tax Status Form (PDF). It may be required that Section 152 dependent status be redeclared each tax year.

Employees are strongly encouraged to consult with a tax advisor before declaring a same-sex partner satisfies each of the above requirements to be considered a qualifying relative as defined by the IRS. The State will assume your same-sex partner DOES NOT qualify as your tax dependent for tax-free health insurance if you do not file a declaration that the same-sex partner meets the requirements to be considered a qualifying relative.

Please note:

This information is not intended as tax advice but rather to alert employees of potential tax ramifications and IRS rules.

The State recommends all employees wishing to enroll their same-sex partner under a State-sponsored plan consult with a qualified tax advisor to fully understand the tax issues involved.

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Select Benefits — Benefits to Suit You

Select Benefits brings choice to your benefit plans. Because you may have needs that are different from your co-workers and friends, with *Select Benefits* you create a personal benefit program from a range of benefits and levels of coverage. Best of all, you can spend your dollars – and the State’s – for benefits that better meet your needs. Here’s how it works:

- ❶ With *Select Benefits*, the State allocates the money it spends on your health benefits as “Benefit Credits.” If you work part-time, you get Benefit Credits only if you elect health coverage.
- ❷ You then consider the monthly cost of each option and decide which benefits to buy.
- ❸ After making your choices, if the total (excluding any contributions to the Dependent Care Assistance Plan), is:
 - *the same* as your Benefit Credit amount, there is no affect on your pay.
 - *more* than your Benefit Credit, you pay the difference. You may be able to pay the difference through pretax payroll deductions. This means deductions are withheld from your pay before federal taxes are computed, which reduced your taxable income. Additional payments for coverage of a same-sex partner may not be eligible for pretax payroll deduction. In that situation, both the additional payments and federal taxes will be withheld from your pay. The difference is deducted from your paychecks twice per month in equal amounts throughout the benefit year.

Consider Your Choices

Listed at the right are the *Select Benefits* for which decisions will be required. More details about these important benefits are provided later in this booklet. During this special enrollment, members who enroll eligible same-sex partners have the opportunity to change insurance coverage.

Your *Select Benefits* Choices

- Medical
- Dental
- Vision
- Life Insurance
- Accidental Death and Dismemberment
- Survivor Benefits
- Disability Benefits (short-term and long-term)
- Health Flexible Spending Account (HFSA)
- Dependent Care Assistance Plan (DCAP)

Changing Your Coverage

You can change your mind about any of your 2007 benefit choices as long as you re-enroll before the December 8, 2006 deadline. The only time you *can* change your coverage other than during this special enrollment, is within 30 days of a “qualified status change.” These include meeting the eligibility requirements for:

- gaining or losing a dependent through birth, adoption, marriage, meeting the eligibility criteria for establishing a same-sex partner relationship, divorce, or death.
- dependent is no longer eligible under the terms of the plan.
- spouse or eligible same-sex partner terminating employment, beginning an extended period of layoff or leave without pay, or beginning new employment.
- you or your spouse or eligible same-sex partner changing employment status from full-time to part-time or vice versa.
- your spouse or eligible same-sex partner having a significant change in his or her health coverage caused by his or her employment.

Your change in benefits must be consistent with the status change. For example, if you had a baby, you could elect Dependent Care. You may change life insurance or disability selections at any time.

Medical Plan

Your medical coverage helps you and your eligible dependents pay for hospital, surgical, and other medical expenses. You can choose from the three different *Select Benefits* medical options listed in the comparison chart below.

When you enroll an eligible same-sex partner and any eligible children of a same-sex partner, they are considered “dependents” under the medical plan, even if they do not qualify to be claimed as “dependents” on your Federal tax return. Your dependents, if any, are covered in *Select Benefits* medical plans, as follows:

- When you choose Standard or Economy medical coverage, you and your eligible dependents are covered under the same option.
- If you select the Premium Employee/Standard Family Plan, you will be covered under the

Premium Plan, while your dependents, if any, will be covered under the Standard Plan. If you select Employee and Family coverage under the Premium Plan, you and your family will be covered under the Premium Plan.

You’ll see that the deductible, coinsurance, and out-of-pocket maximums are different for each option. To determine which plan is right for you, think about how much you can afford out of your own pocket to pay for medical expenses, including the price for coverage shown on the enclosed Personal Fact Sheet.

We want to be sure that all eligible State employees have medical coverage in the event of serious illness or injury, so you are required to choose a medical option. If you have other coverage through another source, you may want to choose the Economy Plan.

A Comparison of Medical Plans			
	Premium	Standard	Economy
<i>Annual Deductible</i>			
<i>Individual</i>	\$250	\$250	\$500
<i>Family</i>	\$500	\$500	\$1000
<i>Coinsurance</i>	90%	80%	70%
<i>Annual Out-of-Pocket Maximum</i>	\$300 per person; does not include deductible	\$1,000 per person; does not include deductible	\$2,000 per person; does not include deductible

Prescription Drugs

Prescription drugs are the fastest growing cost in most health plans, including ours. Higher claim costs from prescription drugs, as with any other expense, means higher premium payments to all participants in the plan. There are several ways to save on prescription drug costs including purchasing a generic or lower cost brand name drug, using the mail order pharmacy for maintenance drugs, or both.

The mail order pharmacy is simple to use for maintenance drugs. You need a prescription from your doctor which allows you to receive a 90-day supply at a time for up to one year. The mail order pharmacy form, available from our office or web site, should be sent with the prescription and your copayment. The pharmacy will send your prescription by return mail along with information on calling to order refills. You’ll save money on the copays, too!

Prescription Drug Coverage			
		Up to 30-Day Supply	31 to 90-Day Supply
<i>Participating Pharmacy</i>	All Drugs	20% copay	20% copay
	Minimum	\$8 copay	\$16 copay
	Maximum	\$50 copay	\$100 copay
<i>Mail Order</i>	Generic	\$8 copay	
	Brand Name	\$20 copay	
<i>Annual Copay Maximum</i>		\$1,000 Individual \$2,000 Family	
Prescriptions filled at a nonparticipating pharmacy or without the pharmacy card are subject to deductible and paid at 60 percent.			

Dental Plan

You may change your Dental level of coverage during this special enrollment only.

Dental Service Types

- Preventive Services include regular exams, x-rays, and routine cleanings.
- Restorative Services include fillings, extractions, and periodontics (gum work).
- Prosthetic Services include crowns, bridges, inlays, and dentures.
- Orthodontia Services include braces (installation, adjustments, and removal) and retainers.

A Comparison of Dental Plans			
	<i>Premium</i>	<i>Standard</i>	<i>Preventive</i>
<i>Annual Individual Deductible</i>			
<i>Preventive</i>	\$0	\$0	\$25
<i>Restorative</i>	\$25	\$25	N/A
<i>Prosthetic</i>	with restorative	with restorative	N/A
<i>Orthodontia</i>	\$0	N/A	N/A
<i>Coinsurance</i>			
<i>Preventive</i>	100%	100%	100%
<i>Restorative</i>	85%	85%	N/A
<i>Prosthetic</i>	75%	50%	N/A
<i>Orthodontia</i>	50%	N/A	N/A
<i>Annual Individual Maximum Benefit</i>	\$2,500 per person	\$1,500 per person	\$500 per person
<i>Orthodontia Individual Maximum Lifetime Benefit</i>	\$2,000 per person	Not covered	Not covered

Audio Plan

The Audio Plan covers exams and hearing aids up to \$800 maximum every three consecutive years.

Benefits are described in your health booklet which is available on the Internet at www.state.ak.us/drb, or from the Division of Retirement and Benefits.

Vision Plan

You may change your Vision Plan level of coverage during this special enrollment only.

You are not required to choose a vision plan. Be sure to consider any other vision coverage available from any other plan.

The Standard Plan is processed by the claims administrator. You may use any licensed provider in the Standard Plan, but may be required to file a claim for reimbursement.

The Managed Care Plan (coordinated through Vision Service Plan) requires that you use a participating provider in order to receive the highest level of benefits. Pre-certification of services is required by calling VSP prior to making your appointment.

A Comparison of Vision Plans		
	<i>Standard Plan</i>	<i>Managed Care Plan</i>
<i>Provider</i>	Can use any qualified provider	Use VSP providers for best benefits
<i>Annual Individual Deductible</i>	\$0	\$10 exam \$25 for lenses/frames combined
<i>Exam Frequency Reimbursement</i>	One per benefit year 90%	One per benefit year 100% at preferred provider
<i>Lenses Frequency Reimbursement</i>	One pair per benefit year 90%	One pair per benefit year 100% at preferred provider
<i>Contacts Frequency Reimbursement Annual Maximum</i>	One pair per benefit year 90% up to the annual maximum \$170 per individual	One pair every two benefit years \$105 in lieu of lens/frame benefit \$105 per individual
<i>Frames Frequency Reimbursement Annual Maximum</i>	One pair every two benefit years 90% up to the annual maximum \$90 retail maximum per individual	One pair every two benefit years Up to \$50 wholesale allowance
<i>Optional Items</i>	None covered	Covers: Anti-reflective coating Progressive lenses Scratch-resistant coating Polycarbonate lenses
<i>Corrective Laser Eye Surgery</i>	Not covered	Not covered but discounts available at preferred providers
<i>Annual Individual Maximum Benefit</i>	\$350 per person	N/A

Options such as tinting or oversized lenses are not covered under either vision plan.

Life Insurance

The plans you make now—and the benefits you choose—can make a difference to your family later. *Select Benefits* lets you customize the amount of life insurance that is right for your situation.

Basic Life/AD&D

Under the Group Life Insurance Plan, the State automatically provides you with:

- \$2,000 Basic Life Insurance.
- \$5,000 Accidental Death and Dismemberment (AD&D) coverage.

If you have eligible dependents, your spouse or same-sex partner, or each dependent child are insured for \$1,000 under the Group Life Insurance, Basic Life Plan.

A beneficiary designation form for this insurance coverage is included in this packet. This form may be completed, changed, and filed at any time, and is not subject to the deadlines of this special enrollment.

Travel Accident

An additional \$100,000 is payable if your death is accidental and occurs while traveling for the State.

Optional Life/AD&D

In addition, you may choose to enroll in Optional Life Insurance also provided under the Group Life Insurance Plan. The amount available is equal to your annual income rounded to the next highest \$1,000. The maximum amount is \$60,000 (\$100,000 for the Supervisory Bargaining Unit).

If you die from any cause, Optional Life Insurance pays your beneficiary the full amount of your insurance. If you die from an accident, your Optional AD&D insurance pays your beneficiary an additional benefit equal to the value of your Optional Life Insurance benefit.

Check your first payroll check stub of the month for the deduction “Life Ins” to determine if you have this benefit or contact the Division of Retirement and Benefits.

Optional Life premiums are deducted after taxes have been paid.

Select Benefits Life

Additionally, you may choose from one of the following Life Insurance coverage levels offered through *Select Benefits*:

- No coverage
- \$10,000
- \$20,000
- \$30,000
- \$40,000
- \$48,000

There are a few rules to keep in mind when selecting your coverage level:

- No more than \$10,000 of *Select Benefits* Life Insurance may be selected if you are electing Survivor Benefits. (See page 8 for information on Survivor Benefits.)
- If you wish to elect *Select Benefits* Accidental Death and Dismemberment, you must select at least \$10,000 of *Select Benefits* Life Insurance. (See page 8 for information on AD&D).

Accidental Death and Dismemberment (AD&D) Insurance

Life Insurance provides benefits if you die for any reason. Accidental Death and Dismemberment insurance helps provide even more financial protection if something happens to you. If you die because of an accident, your beneficiary will get money from your Life Insurance and your AD&D Insurance. It also provides money if you suffer certain injuries as the result of an accident, such as the loss of a limb or your eyesight. You may also select coverage for your family members.

When purchasing AD&D coverage, you have a choice of coverage levels:

- Employee only
The full benefit amount for employee only coverage is \$100,000.
- Employee and family
The benefit amounts that are paid to you or your beneficiaries are based on the make-up or composition of your family at the time of the loss.

If you want to purchase AD&D coverage, you must also elect at least \$10,000 of *Select Benefits* Life Insurance coverage for yourself.

AD&D Coverage Options

Family Composition at Time of Loss	Full Benefit Amount
<i>Employee, Spouse/Same-Sex Partner, and Dependent Children</i>	
Employee	\$ 100,000
Spouse/Same-Sex Partner	\$ 40,000
Each child	\$ 5,000
<i>Employee and Spouse/Same-Sex Partner</i>	
Employee	\$ 100,000
Spouse/Same-Sex Partner	\$ 50,000
<i>Employee and Dependent Children</i>	
Employee	\$ 100,000
Each child	\$ 10,000

The amount of the benefit is also based on the severity of the loss.

Type of Permanent Loss	Percentage of AD&D Coverage Paid
Life	100%
Both eyes, feet, hands, or any combination thereof	100%
One eye, one foot, or one hand	50%
Thumb and index finger of same hand	25%

Survivor Benefits

Survivor Benefits pay your beneficiary an ongoing monthly payment, rather than a one-time life insurance payment. The amount of the monthly payment depends on how long you elect to have the payments made. Your Survivor Benefit options are listed to the right.

This coverage is not available, however, if you have elected more than \$10,000 of *Select Benefits* Life Insurance coverage.

Survivor Benefit Options

- 5 years at \$765 per month
- 10 years at \$455 per month
- 15 years at \$360 per month
- 20 years at \$315 per month
- 25 years at \$290 per month
- 30 years at \$275 per month
- No coverage

Disability Benefits

The State recognizes that one of the most important possessions you have is your ability to earn a living. You want to protect your family, your home, and all the things for which you have worked so hard. Short and Long-Term Disability Insurance can provide you with income if an illness or injury keeps you from working.

Benefits are payable only if you are “totally disabled.” You are considered totally disabled if you are unable to work at any gainful occupation (not just your own occupation) and are under the care of a physician.

Other Points to Consider

When selecting disability coverage that is right for you, please remember:

- For the first 24 months of disability coverage, no benefits are payable if you are disabled due to a pre-existing condition. A pre-existing condition is an illness or injury which was diagnosed, treated, for which you have been taking medication, or for which a reasonable person would have sought treatment in the 12 months before your coverage began. At the end of the 24 months of coverage, the limitation is canceled.
- The amount of your Short-Term and Long-Term Disability benefit is reduced by the amount of benefits available from any retirement plan, including your retirement system, Social Security disability, other group disability plan, workers’ compensation, or other sources (see your *Select Benefits* Information Booklet for details).
- The minimum monthly Long-Term Disability benefit payable after all offsets is \$100.
- The maximum monthly Long-Term Disability benefit payable is \$8,000.

Short-Term Disability

Short-Term Disability (STD) provides you continuing income if you become injured or disabled and are unable to work. Benefit payments begin after 30 days of disability and after all paid leave is exhausted. You receive benefits for up to 180 days from the date of your disability.

Short-Term Disability Options

- Plan A – \$210 per week
- No coverage

Long-Term Disability

If you remain totally disabled after 180 days, Long-Term Disability (LTD) coverage pays you a continuing monthly benefit. The length of time your benefit is paid depends on how old you are when you became disabled.

Long-Term Disability Options

- Plan B – 50% of base monthly pay
- Plan C – 70% of base monthly pay
- No coverage

Reimbursement Accounts

With the *Select Benefits* Reimbursement Accounts, you can set aside money to pay for certain health or day care expenses on a tax-free basis. This means you pay less in taxes each year!

Here's How They Work

Each benefit year, you decide the amount you want to contribute, up to the limits, on a pretax basis. During the benefit year, you file claims and are reimbursed with tax-free dollars from the account. You benefit from reduced taxes, because you don't pay taxes on the dollars you contribute to your accounts.

Some Important Rules

The government imposes certain restrictions on Reimbursement Account plans to give you these pretax advantages.

- During this special enrollment, you can enroll in, cancel, or change your Health Flexible Spending Account (HFSA).
- Amounts are held in separate Health and Dependent Care accounts. Balances cannot be moved back and forth.
- Our benefit year runs from July 1, 2006, to June 30, 2007. Therefore, you lose any portion of your account balance not used for expenses incurred by June 30, 2007. You must budget contributions carefully or "use it or lose it."
- Services for eligible expenses must be received while you are covered by the plan—coverage stops during periods of leave without pay and at termination. Under HFSA, coverage also stops when you move to a bargaining unit which doesn't participate in the *Select Benefits* health plan, AlaskaCare. In addition, services must be received prior to the end of the benefit year, June 30. Claims for the benefit year must be filed within 60 days of the end of the benefit year.
- Expenses for services received by same-sex partners and their children do not qualify for HFSA reimbursement unless the same-sex partner and children qualify as dependents under Section 152 of the Internal Revenue Code.

Health Flexible Spending Account

The Health Flexible Spending Account (HFSA) lets you pay for health care expenses not covered by your insurance. You choose how much to contribute to the account. The minimum contribution is \$20 per month, the maximum is \$5,000 per year.

What Are Eligible Health Care Expenses?

You can use the money you contribute to the account for the following health care expenses:

- Deductibles and copayments
- Amounts over reimbursed expenses
- Orthodontia
- Vision care (*including eyeglasses and contact lenses*)
- Hearing aids and exams
- Medicine and drugs prescribed by a physician

For a detailed listing of eligible expenses, refer to *Select Benefits* Information Booklet or Internal Revenue Service (IRS) Publication 502, available from our web site, from your local IRS office, or their web site at www.irs.gov.

Claims Submission

Claims to the HFSA may be submitted in one of

two ways. If you enroll, you must select how you want your claims to be handled.

- *Streamlined claims submission* — With this option, claims are sent to the Claims Administrator office by you or your provider as normal. Any amounts that are unpaid by the health plan are electronically transferred to the HFSA administrator. **You cannot elect this option if you or any of your eligible dependents have any other health coverage.** This includes a second State of Alaska plan (such as coverage through your spouse) or any other health insurance plan.
- *Direct claims submission* — With this option, you submit your claims to the HFSA administrator *after* receiving your explanation of benefits (EOB) from your group health plan(s). If you or any of your eligible dependents have more than one health plan, you must submit the claim with copies of the EOBs from all plans. **This is the only option available if you or any of your eligible dependents have more than one health plan.**

Under either option, the HFSA administrator will process the claim, sending an explanation of the payment and check directly to you.

Dependent Care Assistance Plan

The Dependent Care Assistance Plan (DCAP) lets you pay expenses on a tax-free basis for dependent care. You can be reimbursed for these expenses if your dependents require care because you work full-time or part-time and fall under one of these categories:

- You are a single parent
- Your spouse also works
- Your spouse is a full-time student
- Your spouse is disabled

Who Are Your Eligible Dependents?

Your eligible dependents are those individuals **listed as a dependent on your federal income tax return** and may include:

- Your dependent children under the age of 13.
- Your same-sex partner, parent, or child over the age of 13, who is physically or mentally incapable of self-support and who lives in your home at least eight hours a day.

What Are Eligible Expenses?

You can be reimbursed for the following eligible expenses:

- Dependent care centers — if the care is for more than six individuals and complies with all state and local laws.
- In-home services — if the care of a dependent is included and the person providing services is not your dependent child under age 19, or any other person you claim as a dependent.
- Services provided by individuals — including relatives, as long as the individual providing care is not your dependent.

To pay for these expenses, contributions must be at least \$25 per month. You may contribute up to a maximum of \$5,000 per calendar year. Keep in mind the amount you contribute may not be greater than your annual income.

Who Will Receive Your Benefits If You Die?

There are valuable benefits to be paid to your beneficiaries if you die. Many people complete beneficiary forms when they are first hired, but forget to update them when they marry, divorce, have a child, or experience a death in the family. Often beneficiaries move, but their addresses aren't updated. This means your benefits could be paid to someone you would prefer not to pay, or benefit payments could be delayed while attempts to locate your beneficiary are made. If you cannot remember the last time you submitted a beneficiary form or who you designated, fill out a new form to ensure your benefits go to the people you want.

The following is a list of benefits that may be available upon your death:

- Pension Benefits (including monthly payment and health benefits for eligible survivors)
- Group Life Insurance Plan
 - Basic Life and AD&D Insurance
 - Optional Life Insurance
- Supplemental Annuity Plan
- *Select Benefits* Life Insurance/AD&D
- *Select Benefits* Survivor Benefits
- Alaska Deferred Compensation Plan
- Unpaid Compensation (last paycheck plus leave not taken)

A complete packet of beneficiary forms is available from the Division or on our website at www.state.ak.us/drb.



Must be postmarked or received at the Division by December 8th, 2006.

Same-sex Partner Affidavit

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
www.state.ak.us/dr

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-8600
TDD: (907) 465-2805
Fax: (907) 465-4668



SECTION I. EMPLOYEE/RETIREE INFORMATION

COMPLETE BOTH SIDES

Employee/Retiree Name (Last, First, MI)	Sex M/F <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Retired
Mailing Address (City, State, ZIP+4)			
Same-Sex Partner Name (Last, First, MI)	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number	

Before signing the affidavit and enrolling a same-sex partner in insurance coverage under the state's plans, the employee/retiree and same-sex partner should contact an attorney and tax advisor about possible legal and tax consequences.

To enroll the same-sex partner and any children of the same-sex partner, the employee/retiree must also complete the applicable dependent enrollment forms.

SECTION II. AFFIDAVIT

Under the penalty of perjury, we each hereby certify that we each:

- (1) are at least 18 years old and are each competent to enter into a contract;
- (2) have been in an exclusive, committed, and intimate relationship with each other for the last consecutive 12 months and intend to continue that relationship indefinitely;
- (3) have resided together at a common primary residence for the last 12 consecutive months and intend to reside together indefinitely;
- (4) consider ourselves to be members of each other's immediate family;
- (5) are not related to each other to a degree of closeness that would preclude us from marrying each other in Alaska if we were of the opposite sex from each other;
- (6) are neither one of us legally married to anyone else;
- (7) have not executed an affidavit affirming same-sex partner status with anyone else within the last 12 months;
- (8) are each other's sole domestic partner and are each responsible for the common welfare of the other;
- (9) share financial obligations, including joint responsibility for basic living expenses and health care costs;
- (10) understand that, under applicable federal income tax law, payments for medical coverage of a same-sex partner or child of a same-sex partner may not be eligible for pre-tax treatment, and coverage of a same-sex partner may result in additional imputed taxable income to the covered employee, retirement system member, or survivor and related withholding for payroll, income, or pension and annuity taxes; and
- (11) understand that, in addition to requirements of this section, there are terms and conditions of coverage set out in each group policy, state plan of self-insurance, or alternative insurance program to which we are bound.

SECTION III. SUPPORTING DOCUMENTATION

In order to enroll a same-sex partner in group insurance coverage, you must provide the Plan Administrator with documentation establishing that you and your same-sex partner meet at least five of the eight criteria set out below.

Please check five boxes, and attach the supporting documentation. You should submit supporting documentation within 90 days of filing the affidavit and enrollment form. Payment will not be made on covered claims until documentation is received and verified. All determinations of whether a particular item of proof is acceptable to prove financial interdependence shall be made by the Plan Administrator, in its sole and absolute discretion.

Please check five boxes that prove:

- joint interest in real property, as evidenced by title or mortgage, lease, or rental agreement, by the employee or retirement system member and the same-sex partner.
 - joint ownership or purchase of a motor vehicle by the employee or retirement system member and the same-sex partner.
 - joint ownership of a checking, savings, or investment account or joint liability for a loan or credit account by the employee or retirement system member and the same-sex partner.
 - the same-sex partner is named as primary beneficiary for a life insurance policy of the employee or retirement system member.
 - the same-sex partner is named as primary beneficiary for the employee's or retirement system member's pension or annuity plan benefits, deferred compensation plan, Individual Retirement Arrangement or Account, 401(k) plan, Keogh plan, or other tax-deferred or taxable plan.
 - the same-sex partner is named as primary beneficiary in the employee's or retirement system member's will.
 - the same-sex partner has authority to deal with property owned by the employee or retirement system member under a valid written power of attorney.
 - the employee or retirement system member has given the same-sex partner written authority to make decisions concerning the employee's or retirement system member's health and well-being if the employee or retirement system member is unable to do so.
- Check this box if you provide more than one-half of your same-sex partner's support in accordance with IRS Regulations.

In completing this form, the undersigned declare under penalty of perjury that the undersigned employee/member and same-sex partner meet the requirements of 2 AAC 38.010(b) that are set out in the affidavit. The undersigned employee/member of state retirement system agrees to notify the administrator in writing within 30 days after eligibility ends under the above requirements.

Signature of Employee/Retiree Date Signature of Same-Sex Partner Date

On this _____ day of _____, 20____, personally appeared before me _____ whose identity I proved on the basis of satisfactory evidence to be the signer of the participant's signature above, and he/she acknowledged that he/she executed it.

Notary Public _____

SEAL OR
STAMP
REQUIRED

State of _____ and Borough/County of _____

Residing at _____ Commission Expires _____

Office Use Only:

Accepted Rejected Date verified _____ Initials _____



Health Dependent Enrollment

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
www.state.ak.us/dr/b

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-8600
TDD: (907) 465-2805
FAX: (907) 465-4668

PLEASE TYPE OR PRINT CLEARLY

Must be postmarked or received at the Division by December 8th, 2006.

PERSONAL DATA		
Employee Name (Last, First, MI)	Social Security Number	Contact Telephone Number
Are you covered by any other health plan as a participant or dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Carrier _____		
DEPENDENT INFORMATION		
<input type="checkbox"/> I HAVE NO ELIGIBLE DEPENDENTS (Skip to Certification at Bottom) <input type="checkbox"/> MY ELIGIBLE DEPENDENTS ARE LISTED BELOW (Attach additional sheets if necessary)		
Dependent (Last, First, MI)	Social Security Number	Date of Birth
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Same-Sex Partner <input type="checkbox"/> Employee's Child <input type="checkbox"/> Employee's Step-Child <input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	Is this dependent covered by another health plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Carrier _____
Mailing Address (City, State, ZIP+4)—if different from employee's		
Dependent (Last, First, MI)	Social Security Number	Date of Birth
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Same-Sex Partner <input type="checkbox"/> Employee's Child <input type="checkbox"/> Employee's Step-Child <input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	Is this dependent covered by another health plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Carrier _____
Mailing Address (City, State, ZIP+4)—if different from employee's		
Dependent (Last, First, MI)	Social Security Number	Date of Birth
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Same-Sex Partner <input type="checkbox"/> Employee's Child <input type="checkbox"/> Employee's Step-Child <input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	Is this dependent covered by another health plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Carrier _____
Mailing Address (City, State, ZIP+4)—if different from employee's		
Dependent (Last, First, MI)	Social Security Number	Date of Birth
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Same-Sex Partner <input type="checkbox"/> Employee's Child <input type="checkbox"/> Employee's Step-Child <input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	Is this dependent covered by another health plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Carrier _____
Mailing Address (City, State, ZIP+4)—if different from employee's		
CERTIFICATION AND SIGNATURE		
I certify that the above information is true and correct to the best of my knowledge. I understand that making false statements for the purpose of obtaining benefits is an offense punishable by law.		
Employee Signature	Date	

SELECT BENEFITS HEALTH DEPENDENT ENROLLMENT FORM

During this special enrollment, you may add an eligible same-sex partner and eligible children of a same-sex partner as dependents to be covered on a "Health Dependent Enrollment form." Please complete this form and return it to the Division of Retirement and Benefits. If your dependents later change due to marriage, meeting or ceasing to meet the eligibility requirements for same-sex partner status, divorce, birth, or adoption, you must complete a "Health Dependent Change form" to add or delete dependents. Failure to complete these forms when required may delay payment of claims for your dependents.

DEPENDENTS WHO ARE COVERED

The following dependents may be covered:

- Your spouse. You may be legally separated but not divorced.
- Your same-sex partner.
- Your dependent children up to 23 years of age *only* if they are:
 - Your natural children, stepchildren, children of your same-sex partner, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are legal, court-appointed guardian (if the child is not your or your same-sex partner's natural born child, please include a copy of the adoption paper work or court orders);
 - Unmarried and chiefly dependent upon the employee for support;
 - Living with you in a normal parent-child relationship;
 - ◆ This provision is waived for natural/adopted children of the employee who are living with a divorced spouse, assuming all other criteria are met.
 - ◆ Stepchildren or children of a same-sex partner must live with the employee 50% or more of the time to be covered under this plan.
 - In addition to meeting the above criteria, if your children are between the ages of 19 and 23, they must be attending school regularly on a full-time or half-time basis.

Children incapable of employment because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 19 and the children must continue to rely chiefly on you for support. You must furnish the claims administrator evidence of the incapacity, proof that the incapacity existed before age 19 and proof of financial dependency. Children are covered as long as the incapacity exists and they meet the definition of children, except for age. Periodic proof of the continued incapacity may be required.

Definition

The member is the active employee who is enrolled and entitled to receive benefits in the Select Benefits plan.

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Dependent Eligibility Documentation

If the member's name is not listed on the documentation, additional documents may be required. Copies of original documents are acceptable unless otherwise specified. Original documents will be returned.

Dependent Type	Document(s) Required	Copies Acceptable
Spouse	Marriage Certificate. <i>Member may be legally separated but not divorced.</i>	Yes
Natural Child	Birth Certificate issued by state or country of birth. <i>Birth certificates issued by a hospital are not adequate.</i>	Yes
Stepchild	In addition to Birth Certificate—Marriage Certificate and Custody Agreement. <i>Must live with member more than 50 percent of the time.</i>	Yes
Foster Child	In addition to Birth Certificate—Placement order or decree issued by a court. <i>Must be placed through a state foster child program.</i>	Original or Certified copy
Legally Adopted Child	In addition to Birth Certificate—Decree of adoption or adoption order issued by court. <i>If member's name is listed on birth certificate, adoption paperwork is not required.</i>	Original or Certified copy
Child in Member Custody	In addition to Birth Certificate—Pre-Adoption order or initial placement order issued by court, tribal council, or tribal court.	Original or Certified copy
Legal Guardianship	In addition to Birth Certificate—Guardianship order or plan issued by court.	Original or Certified copy
Foreign Adoption	In addition to Birth Certificate—Foreign adoption approval by the United States Immigration and Naturalization Service (INS), legal adoption documentation from country of adoption, or legal adoption documentation from the United States. If not final, member must have physical custody and adoption proceedings underway. <i>If member's name is listed on birth certificate, adoption paperwork is not required.</i>	Original or Certified copy
Tribal Adoption	In addition to Birth Certificate—Resolution from the tribal council (a certificate of recognition or letter of support for the adoption that identifies the biological and adoptive parents) or tribal court documentation, if the adoption was finalized by the tribal court. <i>If member's name listed on birth certificate, adoption paperwork is not required.</i>	Yes
Incapacitated Child	In addition to specified documentation above—Premera letter approving an incapacitated child application. Updated approval may be required. <i>Incapacity must have existed before age 19.</i>	Yes
Same-sex Partner	Same-sex Partner Affidavit and required documentation listed on the affidavit and Declaration of Tax Status form.	Yes
Child of Same-sex Partner	Applicable documentation requested above proving relationship of child to both the same-sex partner and member.	Yes

All documentation issued by a foreign country must be accompanied by a translation.

If you have a child between the ages of 19 and 23, proof of student status will be requested by Premera.

[g:/publications/benefits section/sspb open enrollment/dependent eligibility documentation matrix.pmd](g:/publications/benefits%20section/sspb%20open%20enrollment/dependent%20eligibility%20documentation%20matrix.pmd) (Rev: 10/06)

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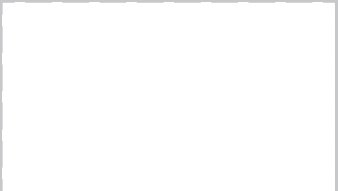
Declaration of Tax Status Alaska Benefit Plans

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
www.state.ak.us/drb

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-8600
TDD: (907) 465-2805
Fax: (907) 465-4668



The State of Alaska offers coverage for same-sex partners and their eligible dependent children. In order to ensure proper tax treatment of the benefits for these dependents, the State must know the federal tax status of each dependent enrolled. The tax status of the dependent does not affect their eligibility for coverage but does impact the tax treatment of that coverage. The flowchart on the back of this form is provided to assist you in determining and verifying the federal tax status of your same-sex partner and dependent children. The chart is provided as an overview of the tax rules but given their complexity, we recommend you consult a tax advisor regarding your specific circumstances. Additional information regarding the tax implications is provided on page 2 and 3.

List every dependent you are enrolling for health coverage on your health dependent enrollment form in this packet and indicate whether they are a federal tax dependent, or not, after following the flowchart on the back of this form.

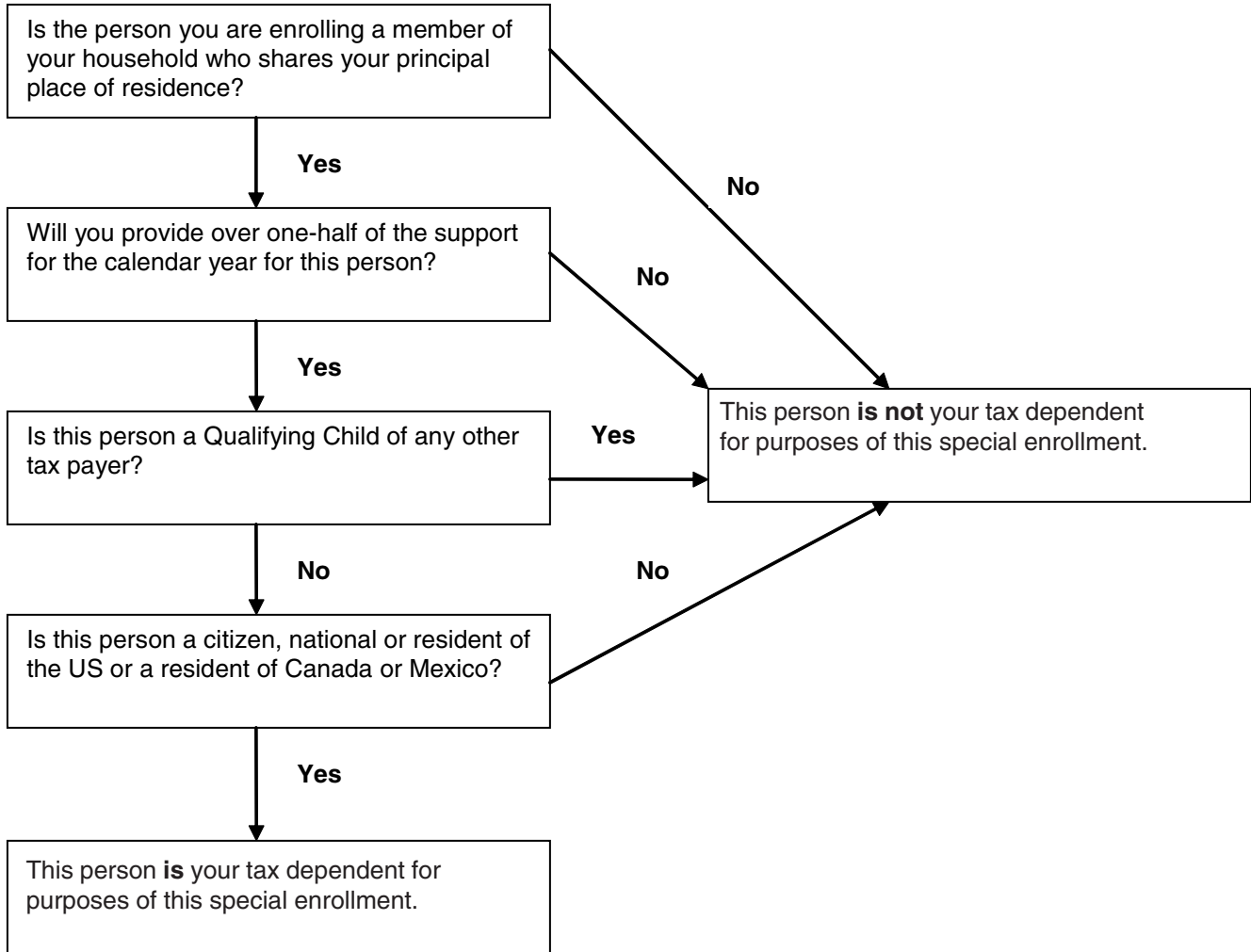
Member Name		Member SSN
Health Dependent Name		Relationship to Member
		<input type="checkbox"/> This person is my tax dependent for purposes of this health plan. <input type="checkbox"/> This person is not my tax dependent for purposes of this health plan.
Social Security Number	Date of Birth	
		<input type="checkbox"/> This person is my tax dependent for purposes of this health plan. <input type="checkbox"/> This person is not my tax dependent for purposes of this health plan.
Social Security Number	Date of Birth	
		<input type="checkbox"/> This person is my tax dependent for purposes of this health plan. <input type="checkbox"/> This person is not my tax dependent for purposes of this health plan.
Social Security Number	Date of Birth	
		<input type="checkbox"/> This person is my tax dependent for purposes of this health plan. <input type="checkbox"/> This person is not my tax dependent for purposes of this health plan.
Social Security Number	Date of Birth	
		<input type="checkbox"/> This person is my tax dependent for purposes of this health plan. <input type="checkbox"/> This person is not my tax dependent for purposes of this health plan.
Social Security Number	Date of Birth	
		<input type="checkbox"/> This person is my tax dependent for purposes of this health plan. <input type="checkbox"/> This person is not my tax dependent for purposes of this health plan.
Social Security Number	Date of Birth	

I understand that my employer has a legitimate need to know the federal income tax status of my relationship with my same-sex partner and their child/children. I certify that the information I have listed above is true. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand that if any information I have provided is false or misleading, it could result in disciplinary action up to and including termination of employment or ineligibility under the health plan. I agree to notify the Division if there is any change in these circumstances within 30 days of the change. I am aware that changes may impact the tax treatment of my coverage.

Member Signature Date

Declaration of Tax Status Alaska Benefit Plans

Answer the following questions for each person you listed on the other side of this form:





Select Benefits Same-Sex Partner Special Enrollment

November 20, 2006 through December 8, 2006

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
www.state.ak.us/drbb

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-8600
TDD: (907) 465-2805
Fax: (907) 465-4668

NAME _____ SOCIAL SECURITY NUMBER _____

Use this form to enroll. Price tags are your monthly costs for coverage; use the enclosed premium sheet to calculate your premiums. Enroll during this special enrollment period by completing this form and sending it and any required same-sex partner documents, to the address listed above. Enrollment documents must be postmarked by or received in the Division by December 8, 2006. Circle the option code and write the code and price tag in the space provided.

BENEFIT CREDITS

Monthly Credit: SEE PAGE 26

MEDICAL

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag</u>	<u>Option Code:</u> _____
1	Premium Employee/Standard Family	SEE	
2	Premium Plan Employee and Family	PREMIUM	
3	Standard Plan Employee and Family	CARD	
4	Economy Plan Employee and Family		Price Tag: \$ _____

DENTAL

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag for Employee and Family</u>	<u>Option Code:</u> _____
1	Premium Plan	SEE	
2	Standard Plan	PREMIUM	
3	Preventive Plan	CARD	Price Tag: \$ _____

You may change your dental election only if your current election has been in place for a minimum of 18 months.

VISION

<u>Code</u>	<u>Option</u>	<u>Monthly Price Tag for Employee and Family</u>	<u>Option Code:</u> _____
0	No Coverage	SEE	
1	Standard Plan	PREMIUM	
2	Managed Care Plan	CARD	Price Tag: \$ _____

You may change your vision election only if your current election has been in place for a minimum of 18 months.

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		Price Tag: \$ _____
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	Price Tag: \$ _____

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	Price Tag: \$ _____
5	25 Years at \$290/Month		
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	Price Tag: \$ _____

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	Price Tag: \$ _____

HEALTH FLEXIBLE SPENDING ACCOUNT (HFSA)

<u>Code</u>	<u>Option</u>	<u>Monthly Contribution/Price</u>	<u>Option Code:</u> _____
	<u>HFSA Streamlined</u>		Price Tag: \$ _____
0	No Participation		
1	No streamlined claim submission		
2	Streamlined claim submission (only if you and your dependents have no other health coverage)		

(min: \$20/month, max: \$5,000/benefit year) must be a whole \$ amount

DEPENDENT CARE ASSISTANCE PLAN (DCAP)

	<u>Monthly Contribution/Price Tag</u>	<u>Option Code:</u> _____
0	No Participation	
1	Participation	Price Tag: \$ _____ (without cents)

\$ _____ per month
(min: \$25/month, max: \$5,000/calendar year)

SELECT BENEFITS' EFFECT ON YOUR PAY

- (1) Enter the total monthly prices (excluding your DCAP contribution): \$ _____
- (2) Enter your monthly Benefit Credit: \$(_____)
- (3) Enter the difference between (1) and (2): \$ _____
- (4) Enter the amount of your DCAP contribution: \$ _____

If (1) is greater than (2): The difference will be deducted from your pay on a pre-tax basis, in addition to your DCAP contribution (if any).

As this is a **special enrollment only**, website and telephonic enrollment is not available, **paper enrollment is required.**

Signature _____ Date _____

PREMIUM CARD

ACCIDENTAL DEATH AND DISMEMBERMENT

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

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

SURVIVOR BENEFITS

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

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

SHORT-TERM DISABILITY

Every employee who elects this benefit pays the same premium.

Who is covered	Plan	Monthly Cost
Employee	Plan A \$2.10/week	\$1.96

LONG-TERM DISABILITY

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).

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

HEALTH FLEXIBLE SPENDING ACCOUNT

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.

Minimum Monthly Amount	\$ 20
Maximum Annual Amount	\$5,000

DEPENDENT CARE ASSISTANCE PLAN

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.

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

STATE OF ALASKA SELECT BENEFITS 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.

MEDICAL

*Subject to Legislative appropriation in 2006.

Option	Monthly Cost*
Premium Plan for Employee/Standard Family	\$ 1,000
Premium Plan for Employee and Family	1,179
Standard Plan for Employee and Family	916
Economy Plan for Employee and Family	790

DENTAL

Your Dental election will remain in effect for at least 18 months. Premiums are subject to change.

Option	Monthly Cost for Employee and Family
Premium Plan	\$ 175
Standard Plan	105
Preventive Plan	45

VISION

Your Vision election will remain in effect for at least 18 months. Premiums are subject to change.

Option	Monthly Cost for Employee and Family
No Coverage	\$ 0
Standard Plan	33
Managed Care Plan	22

LIFE INSURANCE

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.

Employee Age	Monthly Cost			
	\$10,000	\$20,000	\$30,000	\$48,000
Under 30	\$.90	\$ 1.80	\$ 2.70	\$ 4.32
30 - 39	1.10	2.20	3.30	5.28
40 - 44	1.80	3.60	5.40	8.64
45 - 49	2.60	5.20	7.80	12.48
50 - 54	4.10	8.20	12.30	19.68
55 - 59	6.10	12.20	18.30	29.28
60 - 64	8.70	17.40	26.10	41.76
65 - 69	12.60	25.20	37.80	60.48
70 - 74	27.90	55.80	83.70	135.92
75 - 79	53.00	106.00	159.00	254.40
80 - 84	75.20	150.40	225.60	360.96
85 and over	115.70	231.40	347.10	555.36

2006 Benefit Credits by Bargaining Unit

BU Code	Bargaining Unit (BU)	Benefit Credit
TA	Alaska Vocational Technical Central Teacher's Assoc.	\$835.00
KK	Confidential Employees	\$835.00
EE	Excluded Employees	\$835.00
XE	Executive Branch Exempt	\$835.00
GC	Correctional Officers	\$838.00
MM	Inlandboatmen's Union	\$852.00★
XJ	Judicial Employees	\$835.00
XL	Legislative Employees	\$835.00
BB	Marine Engineers	\$835.00
SS	Supervisory Employees	\$835.00

★ This rate is subject to change through the collective bargaining process. At this time, the rate of state contribution for these employees have not been determined. Employees may contact their bargaining unit representative or the Division of Retirement and Benefits for further information.

2006 Amendment Select Benefits Insurance Information Booklet

Effective **January 1, 2007**, who may be covered under the health plan is amended to include:

- Same-sex partner as defined and documented by 2 AAC 38.010 - 2 AAC 38.100.
- Eligible child of same-sex partner as defined and documented by 2 AAC 38.010- 2 AAC 38.100.



Beneficiary Designation

Defined Benefit Plan

for Active and Deferred Members

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
www.state.ak.us/drb

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086



Initial Designation Change

READ CAREFULLY BEFORE COMPLETING: This form is for active or deferred members of the Public Employees' Retirement System (PERS Tier I, II, III), Teachers' Retirement System (TRS I, II), Judicial Retirement System (JRS), National Guard Retirement System (NGRS), and the Elected Public Officers Retirement System (EPORS). The person(s) that you designate as your beneficiary or beneficiaries on this form will receive the retirement system benefits payable upon your death. To change your beneficiary or beneficiaries address, marital status, or other information, complete and send a new form to the above address. NOT FOR SBS OR OPTIONAL LIFE INSURANCE.

Section I. Personal Data Is this a new address? Yes No

Employee's Name (Last, First, M.I.)	Social Security Number	Page ____ of ____ (Use only if additional forms are attached)
Mailing Address (City, State, ZIP + 4)	Work Phone Number ()	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Same-sex Partner	Date of Birth	Home Phone Number ()
Employer Name	Employer Number	

Section II. Beneficiary Designation

If you are married or a single parent, see the instructions on the back BEFORE designating your beneficiary or beneficiaries.

Place an "X" in the appropriate box to specify whether the beneficiary is primary or contingent. The "primary" beneficiary or beneficiaries will receive benefits if you die. The "contingent" beneficiary or beneficiaries will receive benefits ONLY if the primary is deceased.

PRIMARY <input type="checkbox"/>	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
Mailing Address (City, State, ZIP + 4)		Social Security Number		
Check whether beneficiary is the primary or contingent		<input type="checkbox"/> Check if this is an address change for your beneficiary		
PRIMARY <input type="checkbox"/>	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
CONTINGENT <input type="checkbox"/>				
Mailing Address (City, State, ZIP + 4)		Social Security Number		
PRIMARY <input type="checkbox"/>	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
CONTINGENT <input type="checkbox"/>				
Mailing Address (City, State, ZIP + 4)		Social Security Number		
PRIMARY <input type="checkbox"/>	Last Name, First, M.I.	Percentage	Date of Birth	Relationship
CONTINGENT <input type="checkbox"/>				
Mailing Address (City, State, ZIP + 4)		Social Security Number		

I hereby certify that the information provided on this form is true and correct to the best of my knowledge. I understand that any deliberate misrepresentation for the purpose of obtaining benefits is an offense punishable by law.

Signature of Employee

Date

Signature of Witness
(must not be a beneficiary)

Date

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 the above 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: _____

Section IV. Same-sex Partner Beneficiary Designation Instructions

If you wish to designate a same-sex partner to receive survivor benefits that may become available upon your death under 14.25.157, 14.25.160, 14.25.162, 14.25.164, 14.25.167, AS 22.25.030, AS 39.35.420, AS 39.35.430, 39.35.440, 39.35.450, or former AS 39.37.060, you must submit the Same-sex Partner Affidavit, and you must provide the documentation, required by 2 AAC 38.010. Your same-sex partner must be the only "primary" beneficiary listed on this form in order to qualify for the survivor benefits provide by the statutes mentioned above.



Beneficiary Designation

PERS/TRS Defined Contribution Retirement Plan

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
www.state.ak.us/dr

Division of Retirement and Benefits
 PO Box 110203
 Juneau, Alaska 99811-0203

Juneau: 465-4460
 TDD: (907) 465-2805
 Fax: (907) 465-3086



SECTION I. PERSONAL DATA

PLEASE TYPE OR PRINT CLEARLY

Employee Last Name	First Name	MI
Mailing Address	Employer	Fund <input type="checkbox"/> PERS OR <input type="checkbox"/> TRS
Social Security Number	Home Telephone ()	Work Telephone ()
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Same-sex Partner		

If you wish to designate your same-sex partner to receive survivor benefits that may become available upon your death under AS 14.25.485, 14.25.487, AS 39.35.890, or 39.35.892, you and your same-sex partner must sign the Same-Sex Partner Affidavit and you must provide the documentation, required by 2 AAC 38.010.

The beneficiary(ies) listed below is the person or persons who will receive your account balance should you die before you have received payment. If you ARE married and list any person other than your spouse as primary beneficiary for over 50% of your account, your spouse must consent to this election by signing this form in front of a notary public or plan representative.

SECTION II. BENEFICIARY DESIGNATION

	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	
	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	
	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	
	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	

If you are married and have designated someone other than your spouse as a 50% or greater primary beneficiary, then your spouse must sign the below waiver in front of a notary public or plan representative for this election to be effective. If you are married and designate your spouse as a beneficiary prior to divorce, except as required by a qualified domestic relations order, this designation will be revoked upon your divorce.

I have read and understand that I am entitled to at least 50% of my spouse's account as indicated in Section I in the event of his/her death. I hereby waive and agree to the above Beneficiary Designation.

SPOUSE'S SIGNATURE

DATE

Spouse's signature witnessed by Plan Representative, Notary Public, or Postmaster:

_____, or

PLAN REPRESENTATIVE (Must be a designated
employee of the Division of Retirement and Benefits)

NOTARY PUBLIC

State of _____; My Commission Exp: _____

Employee Signature

Date



Basic and Optional Life Insurance Enrollment or Change form

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
www.state.ak.us/dr

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-8600
TDD: (907) 465-2805
Fax: (907) 465-4668

THIS FORM IS SUBMITTED FOR (check all that apply):

- BASIC LIFE & AD&D
 OPTIONAL LIFE ENROLLMENT
 BENEFICIARY CHANGE
 CANCELLATION OF OPTIONAL LIFE

EMPLOYEE NAME:		SOCIAL SECURITY NUMBER:	
DATE OF BIRTH:	EMPLOYMENT DATE:	DEPARTMENT:	TELEPHONE NUMBER:

- _____ I want Basic Life and Accidental Death & Dismemberment Insurance Coverage **only**.
(initial)
- _____ I wish to purchase Optional Life and Accidental Death & Dismemberment Insurance in an amount equal to my annual salary. I understand this is in addition to the Basic Life and Accidental Death & Dismemberment Insurance coverage provided by the State. I authorize the appropriate payroll deduction from my earnings each month for the cost of this coverage. I reserve the right to discontinue this Optional Life and Accidental Death & Dismemberment coverage by submitting a written notice to the Division of Retirement and Benefits, at any time.
- _____ I wish to **cancel** my Optional Life and Accidental Death & Dismemberment Insurance Coverage.
(initial)

BENEFICIARY DESIGNATION:

BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP
MAILING ADDRESS		CITY AND STATE	ZIP CODE + 4
THIS BENEFICIARY RECEIVES THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> BASIC LIFE <input type="checkbox"/> OPTIONAL LIFE		THIS BENEFICIARY IS: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT	
		PERCENTAGE %	
BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP
MAILING ADDRESS		CITY AND STATE	ZIP CODE + 4
THIS BENEFICIARY RECEIVES THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> BASIC LIFE <input type="checkbox"/> OPTIONAL LIFE		THIS BENEFICIARY IS: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT	
		PERCENTAGE %	
BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP
MAILING ADDRESS		CITY AND STATE	ZIP CODE + 4
THIS BENEFICIARY RECEIVES THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> BASIC LIFE <input type="checkbox"/> OPTIONAL LIFE		THIS BENEFICIARY IS: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT	
		PERCENTAGE %	
BENEFICIARY LAST NAME	FIRST NAME	M.I.	RELATIONSHIP
MAILING ADDRESS		CITY AND STATE	ZIP CODE + 4
THIS BENEFICIARY RECEIVES THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> BASIC LIFE <input type="checkbox"/> OPTIONAL LIFE		THIS BENEFICIARY IS: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT	
		PERCENTAGE %	
Signature of Employee			Date

INSTRUCTIONS

BASIC LIFE AND AD&D INSURANCE

The State of Alaska provides Basic Life and Accidental Death and Dismemberment (AD&D) Insurance free of charge to permanent and long-term nonpermanent, full-time, and seasonal employees and their families. The benefit pays \$2,000 to your beneficiaries in the event of your death plus an additional \$5,000 if your death is accidental. Benefits are also available if you are dismembered by accidental causes or if your spouse, same-sex partner, or child dies.

Permanent or long-term nonpermanent part-time employees who want to participate in Basic Life must elect coverage within the first 31 consecutive calendar days of employment. They must also be enrolled in the Group Health or Select Benefits Health Plan. Part-time employees pay one-half of the health and life premium cost. Part-time employees who do not enroll within the first 31 days of employment may apply for coverage, subject to approval by the insurance carriers.

For more detailed information regarding the Basic Life Insurance and AD&D plans, please refer to your Employee Group Insurance Information Booklet.

OPTIONAL LIFE AND AD&D INSURANCE

You may choose to enroll in Optional Life for a very low cost. The amount of Optional Life available to you is equal to your annual income rounded to the next highest \$1,000. The maximum available is \$60,000 (\$100,000 for SU employees). The plan pays double the face value if your death is accidental. This plan does not cover your dependents. Premium rates are available from your Human Resource office or the Division of Retirement and Benefits.

If you enroll in the Optional Life Insurance within 31 consecutive calendar days from the date you were hired as a permanent or long-term nonpermanent employee, you do not have to show evidence of your good health. If you do not enroll within that time, you must furnish the life carrier with satisfactory evidence of your good health to become covered. The life carrier may ask that you have a medical examination at your expense. Please contact the division for the necessary forms.

For more detailed information regarding the Optional Life Insurance and AD&D plans, please refer to your Employee Group Insurance Information Booklet.

Optional Life Premiums	
Age	☆Premium Per \$1000
Under 30	\$0.07
30-39	\$0.08
40-44	\$0.14
45-49	\$0.20
50-54	\$0.32
55-59	\$0.48
60-64	\$0.68
65-69	\$0.98
70-74	\$2.17
75-79	\$4.12
80-84	\$5.85
85 & Over	\$9.00

BENEFICIARY DESIGNATION

The beneficiary designation section names the people you want to receive the benefits you have elected in the event of your death. It may also be used to change those names at any time. The section has space for four beneficiaries. If necessary, you may attach additional forms. This section must be completed listing all intended beneficiaries each time this form is used.

1. Enter the beneficiary's name, address and relationship to you.
2. Indicate which benefits this beneficiary should receive if you die. Check Optional Life only if you are enrolled in the program.
3. Indicate whether this beneficiary is primary or contingent. Primary beneficiaries receive the benefit first if you die. Contingent beneficiaries receive the benefit if the primary beneficiary has died.
4. Indicate the percentage of the benefits that you would like this beneficiary to receive. The total percentage given to primary beneficiaries must equal 100%. The total percentage given to contingent beneficiaries must equal 100%.
5. List as many beneficiaries as you like, following the instructions for the first beneficiary in #1 through #4 above.



Supplemental Benefits System Beneficiary (Life, AD&D, Survivor)

1. Employer Code:
0001

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
www.state.ak.us/drb

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-4460
TDD: (907) 465-2805
Fax: (907) 465-4668

SECTION ONE: PERSONAL DATA

PLEASE TYPE OR PRINT CLEARLY

2. EMPLOYEE LAST NAME		3. FIRST NAME		4. M.I.
5. SOCIAL SECURITY NUMBER	6. HOME PHONE ()		7. WORK PHONE ()	

SECTION TWO: BENEFICIARY DESIGNATION

0	8. BENEFICIARY LAST NAME		9. FIRST NAME		10. M.I.	11. RELATIONSHIP		12. SOCIAL SECURITY NUMBER	
	13. MAILING ADDRESS				14. CITY AND STATE			15. ZIP CODE	
	16. I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR				17. I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		18. I WANT THIS BENEFICIARY TO RECEIVE: %		
1	19. BENEFICIARY LAST NAME		20. FIRST NAME		21. M.I.	22. RELATIONSHIP		23. SOCIAL SECURITY NUMBER	
	24. MAILING ADDRESS				25. CITY AND STATE			26. ZIP CODE	
	27. I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR				28. I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		29. I WANT THIS BENEFICIARY TO RECEIVE: %		
2	30. BENEFICIARY LAST NAME		31. FIRST NAME		32. M.I.	33. RELATIONSHIP		34. SOCIAL SECURITY NUMBER	
	35. MAILING ADDRESS				36. CITY AND STATE			37. ZIP CODE	
	38. I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR				39. I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		40. I WANT THIS BENEFICIARY TO RECEIVE: %		
3	41. BENEFICIARY LAST NAME		42. FIRST NAME		43. M.I.	44. RELATIONSHIP		45. SOCIAL SECURITY NUMBER	
	46. MAILING ADDRESS				47. CITY AND STATE			48. ZIP CODE	
	49. I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR				50. I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		51. I WANT THIS BENEFICIARY TO RECEIVE: %		
4	52. BENEFICIARY LAST NAME		53. FIRST NAME		54. M.I.	55. RELATIONSHIP		56. SOCIAL SECURITY NUMBER	
	57. MAILING ADDRESS				58. CITY AND STATE			59. ZIP CODE	
	60. I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR				61. I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		62. I WANT THIS BENEFICIARY TO RECEIVE: %		
5	63. BENEFICIARY LAST NAME		64. FIRST NAME		65. M.I.	66. RELATIONSHIP		67. SOCIAL SECURITY NUMBER	
	68. MAILING ADDRESS				69. CITY AND STATE			70. ZIP CODE	
	71. I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR				72. I WANT THIS BENEFICIARY TO BE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		73. I WANT THIS BENEFICIARY TO RECEIVE: %		

SECTION THREE: SIGNATURE

EMPLOYEE SIGNATURE	DATE
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Supplemental Benefits System Beneficiary Instructions

This form names the people you want to receive Supplemental Life, Accidental Death and Dismemberment, or Survivor insurances you may have elected in the event of your death. It may also be used to change those names at any time. **You are responsible for this form being received by the Division of Retirement and Benefits. Bring or mail this completed form directly to this office. Please Note—To designate beneficiaries for your Alaska Supplemental Annuity Plan (SBS-AP) account, you must complete separately from this form the Alaska Supplemental Annuity Plan Beneficiary Designation form (sbs006).**

SECTION ONE: PERSONAL DATA

Complete this section each time you use this form.

SECTION TWO: BENEFICIARY DESIGNATION

This section has space for up to five beneficiaries. If necessary, attach additional forms. This section must be completed listing all intended beneficiaries each time this form is used.

- 8. - 15. Enter the beneficiary's name, relationship to you, social security number, and address.
- 16. Indicate which benefits this beneficiary should receive if you die. Only check those programs in which you have enrolled.
- 17. Indicate whether this beneficiary is primary or contingent. Primary beneficiaries receive the benefit first if you die. Contingent beneficiaries receive the benefit if the primary beneficiary has died.
- 18. Indicate the percentage of the benefits that you would like this beneficiary to receive. The total percentage given to primary beneficiaries must equal 100%. The total percentage given to contingent beneficiaries must equal 100%.
- 19. - 62. List as many beneficiaries as you like, following the instructions for the first beneficiary in #8 through #18 above.

EXAMPLES

Jane Doe is married with no children. She wishes her husband to receive this benefit if she dies:

BENEFICIARY LAST NAME <i>Doe</i>	FIRST NAME <i>John</i>	M.I. <i>K.</i>	RELATIONSHIP <i>Husband</i>	SOCIAL SECURITY NUMBER <i>123-45-6789</i>
MAILING ADDRESS <i>1000 Any Street</i>		CITY AND STATE <i>Anytown, AK</i>		ZIP CODE <i>99999</i>
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input checked="" type="checkbox"/> LIFE <input type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: <i>100</i> %

Fred Smith is not married and has two children. He has enrolled in life insurance and Accidental Death and Dismemberment (AD&D). He wishes his children to share equally if he dies:

BENEFICIARY LAST NAME <i>Smith</i>	FIRST NAME <i>Jane</i>	M.I. <i>R.</i>	RELATIONSHIP <i>Daughter</i>	SOCIAL SECURITY NUMBER <i>123-45-6789</i>
MAILING ADDRESS <i>1000 "E" Street</i>		CITY AND STATE <i>Anytown, AK</i>		ZIP CODE <i>99999</i>
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input checked="" type="checkbox"/> LIFE <input checked="" type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: <i>50</i> %
BENEFICIARY LAST NAME <i>Smith</i>	FIRST NAME <i>John</i>	M.I. <i>F.</i>	RELATIONSHIP <i>Son</i>	SOCIAL SECURITY NUMBER <i>123-45-6789</i>
MAILING ADDRESS <i>1000 Any Street</i>		CITY AND STATE <i>Anytown, AK</i>		ZIP CODE <i>99999</i>
I WANT THIS BENEFICIARY TO RECEIVE THE FOLLOWING BENEFITS IF I DIE: <input checked="" type="checkbox"/> LIFE <input checked="" type="checkbox"/> AD&D <input type="checkbox"/> SURVIVOR		I WANT THIS BENEFICIARY TO BE: <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTINGENT		I WANT THIS BENEFICIARY TO RECEIVE: <i>50</i> %

SECTION THREE: SIGNATURE

This form must be signed





Alaska Supplemental Annuity Plan Beneficiary Designation

FOR OFFICE USE ONLY



**STATE OF
ALASKA**
Toll-Free: 1-800-821-2251
www.state.ak.us/drb

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086

SECTION I. PERSONAL DATA **PLEASE TYPE OR PRINT CLEARLY**

Employee Last Name	First Name	MI
Social Security Number	Home Telephone ()	Work Telephone ()

Employer (check applicable box): State Political Subdivision (name) _____

The beneficiary(ies) listed below is the person or persons who will receive your account balance should you die before you have received payment. If you ARE married and list any person other than your spouse as primary beneficiary for over 50% of your account, your spouse must consent to this election by signing this form in front of a notary public or plan representative.

SECTION II. BENEFICIARY DESIGNATION

	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	
	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	
	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	
	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	
	Primary	Name	Relationship	Date of Birth	Percentage %
	Contingent				
Mailing Address				Social Security Number — —	

If you are married and have designated someone other than your spouse as a 50% or greater primary beneficiary, then your spouse must sign the below waiver in front of a notary public or plan representative for this election to be effective. If you are married and designate your spouse as a beneficiary prior to divorce, except as required by a qualified domestic relations order, this designation will be revoked upon your divorce.

I have read and understand that I am entitled to at least 50% of my spouse's account as indicated in Section I in the event of his/her death. I hereby waive and agree to the above Beneficiary Designation.

SPOUSE'S SIGNATURE	DATE
Spouse's signature witnessed by: _____, or	
PLAN REPRESENTATIVE (Must be a designated employee of the Division of Retirement and Benefits)	NOTARY PUBLIC State of _____; My Commission Exp: _____

Employee Signature	Date
--------------------	------

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Alaska Deferred Compensation Plan Financial and Beneficiary Changes

FOR OFFICE USE ONLY



Toll-Free: 1-800-821-2251
www.state.ak.us/drb

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-4433
FAX: (907) 465-2341
TDD: (907) 465-2805

Plan STATE OF ALASKA	Group Number 98214-01	Social Security Number — —	Daytime Phone Number
Your Name (Last)	(First)	(Middle Initial)	Effective Date of Change

NOTE: DOLLAR AMOUNT CHANGES ARE EFFECTIVE THE FIRST OF THE MONTH FOLLOWING SUBMISSION, AND CAN BE CHANGED MONTHLY.

- I wish to discontinue my participation in the State of Alaska Deferred Compensation Plan.
- I wish to reinstate deferrals at \$_____ per month.
- I wish to change the amount of my deferral. NOTE: The minimum that you may defer is \$50 per month. The maximum that you may defer is \$15,000 annually or 50% of your taxable earnings, whichever is less. If you are 50 or older, you may contribute an additional \$5,000.
 - Increase from \$_____ to \$_____ per month, for a **new annual amount of \$**_____.
 - Decrease from \$_____ to \$_____ per month, for a **new annual amount of \$**_____.
 - Leave cash-in contribution of \$_____. Continue monthly contributions Discontinue monthly contributions
- I wish to change my mailing address to: _____
- I wish to designate the following beneficiary(s). **The "primary" beneficiary(s) will receive your account if you die and the "contingent" beneficiary(s) will receive your account ONLY if the primary beneficiary is deceased.** If you are married, your spouse must be the beneficiary for at least 50% of your account. If you list any person other than your spouse for more than 50% of your account, you must complete the Deferred Compensation Plan Spousal Beneficiary Waiver showing your spouse's consent. Without your spouse's consent, any beneficiary designation over 50% to a nonspouse is invalid. If you are married and designate your spouse as a beneficiary prior to divorce, except as required by a qualified domestic relations order, this designation will be revoked upon your divorce.

CHECK ONE

<input type="checkbox"/>	Primary	Name	Relationship	Date of Birth	Percentage %
<input type="checkbox"/>	Contingent				
Mailing Address				Social Security Number — —	
<input type="checkbox"/>	Primary	Name	Relationship	Date of Birth	Percentage %
<input type="checkbox"/>	Contingent				
Mailing Address				Social Security Number — —	
<input type="checkbox"/>	Primary	Name	Relationship	Date of Birth	Percentage %
<input type="checkbox"/>	Contingent				
Mailing Address				Social Security Number — —	
<input type="checkbox"/>	Primary	Name	Relationship	Date of Birth	Percentage %
<input type="checkbox"/>	Contingent				
Mailing Address				Social Security Number — —	

6. Other Changes: _____

Signature of Participant	Date
--------------------------	------

STATE OF ALASKA

DESIGNATION OF BENEFICIARY FOR UNPAID COMPENSATION

This form names the people you want to receive unpaid wage compensation in the event of your death. It can also be used to change those names at any time. Your wishes may not be carried out as intended, if the form is not completed correctly.

You are responsible for this form being received in your Human Resources Technical Service Group or Agency. You may also forward this form to Dept. of Administration, Division of Finance, Payroll Section, PO Box 110204, Juneau AK 99811-0204.

Employee Name _____ **Department** _____

Employee SSN _____ **Date of Birth** _____

INITIAL AUTHORIZATION

CHANGE

PRIMARY BENEFICIARY (IES)		CONTINGENT BENEFICIARY (IES)	
Name		Name	
Address		Address	
City, State, & Zip Code		City, State, & Zip Code	
Relationship	Percentage	Relationship	Percentage
DOB if Minor		DOB if Minor	
Name		Name	
Address		Address	
City, State, & Zip Code		City, State, & Zip Code	
Relationship	Percentage	Relationship	Percentage
DOB if Minor		DOB if Minor	
Name		Name	
Address		Address	
City, State, & Zip Code		City, State, & Zip Code	
Relationship	Percentage	Relationship	Percentage
DOB if Minor		DOB if Minor	
Name		Name	
Address		Address	
City, State, & Zip Code		City, State, & Zip Code	
Relationship	Percentage	Relationship	Percentage
DOB if Minor		DOB if Minor	
TOTAL PRIMARY PERCENTAGE % MUST EQUAL		TOTAL CONTINGENT PERCENTAGE % MUST EQUAL	
100%		100%	

Employee Signature	Date	Witness	Date
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INSTRUCTIONS

1. You may designate one primary beneficiary who would be the sole beneficiary.
2. You may designate primary beneficiary(ies) and contingent beneficiary(ies). Primary beneficiaries receive the benefit first if you die. Contingent beneficiaries receive the benefit if the primary beneficiary has died.
3. You may designate any number of beneficiaries to share in any manner you wish. Please designate the percentage to pay each beneficiary. The total percentage of all Primary beneficiaries must equal 100% and the total of all Contingent beneficiaries must equal 100%. List each name separately; attach additional forms if necessary.
4. If you are designating a minor (under 18 yrs of age) as your beneficiary, you must add the minor's date of birth (DOB).
5. Should you wish to change or alter your designation of beneficiary, be sure to complete a new form in its entirety.
6. This form must be witnessed by someone who can verify your identity and who is not your beneficiary.

Return this completed form to your Human Resource Technical Service Group (TSG) or Agency, or you may send it directly to Dept. of Administration, Div. of Finance, Payroll Section, PO Box 110204, Juneau AK 99811-0204.

FORM DBUNCP

Rev. 3/2004

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Title 2 of the Alaska Administrative Code is amended by adding a new Chapter 38 to read:

Regulations have been submitted to the Lt. Governor's Office for filing.

Chapter 38. Employment-Related Benefits for Same-Sex Partners of State Employees and Retirees Under the State's Retirement Systems.

2 AAC 38.010. Same-sex partner insurance coverage.

(a) A state employee or member of a state retirement system who is covered by group insurance under AS 39.30.090 or 39.30.091, such as the state's retiree medical, Select Benefits, or Supplemental Benefits plans, or by an alternative insurance program, such as a union health trust, under an exemption allowed by regulations adopted by the commissioner under AS 39.30.090(a)(2), may enroll the employee's or retirement system member's same-sex partner in the group insurance or alternative insurance program if the employee and same-sex partner, or retirement system member and same-sex partner, meet the requirements of this section.

(b) In order to enroll a same-sex partner in group insurance coverage provided under AS 39.30.090 or 39.30.091 or an alternative insurance program under an exemption allowed by regulations adopted by the commissioner under AS 39.30.090(a)(2), the covered employee or covered member of a state retirement system shall file with the administrator of the health plan or retirement system an affidavit executed by the employee and same-sex partner or the retirement system member and same-sex partner declaring under penalty of perjury that they

- (1) are at least 18 years old and are each competent to enter into a contract;
- (2) have been in an exclusive, committed, and intimate relationship with each other for the last consecutive 12 months and intend to continue that relationship indefinitely;
- (3) have resided together at a common primary residence for the last 12 consecutive months and intend to reside together indefinitely;
- (4) consider themselves to be members of each other's immediate family;
- (5) are not related to each other to a degree of closeness that would preclude them from marrying each other in this state if they were of the opposite sex from each other;
- (6) are neither one of them legally married to anyone else;
- (7) have not executed an affidavit affirming same-sex partner status with anyone else within the last 12 months;
- (8) are each other's sole domestic partner and are each responsible for the common welfare of the other;
- (9) share financial obligations, including joint responsibility for basic living expenses and health care costs;
- (10) understand that, under applicable federal income tax law, payments for medical coverage of a same-sex partner or child of a same-sex partner may not be eligible for pre-tax treatment, and coverage of a same-sex partner may result in additional imputed taxable income to the covered employee, retirement system member, or survivor and related withholding for payroll, income, or pension and annuity taxes; and
- (11) understand that, in addition to requirements of this section, there are terms and conditions of coverage set out in each group policy, state plan of self-insurance, or alternative insurance program to which they are bound.

(c) In order to enroll a same-sex partner in group insurance coverage provided under AS 39.30.090 or 39.30.091 or an alternative insurance program under an exemption allowed by regulations adopted by the commissioner under AS 39.30.090(a)(2), and upon request of the health plan or retirement system administrator after enrollment, the covered state employee or member of a state retirement system shall provide documentation establishing that the employee and same-sex partner, or retirement system member and same-sex partner, meet at least five of the following criteria:

- (1) joint interest in real property, as evidenced by title or mortgage, lease, or rental agreement, by the employee or retirement system member and the same-sex partner;
- (2) joint ownership or purchase of a motor vehicle by the employee or retirement system member and the same-sex partner;
- (3) joint ownership of a checking, savings, or investment account or joint liability for a loan or credit account by the employee or retirement system member and the same-sex partner;
- (4) the same-sex partner is named as primary beneficiary for a life insurance policy of the employee or retirement system member;
- (5) the same-sex partner is named as primary beneficiary for the employee's or retirement system member's pension or annuity plan benefits, deferred compensation plan, Individual Retirement Arrangement or Account, 401(k) plan, Keogh plan, or other tax-deferred or taxable plan;
- (6) the same-sex partner is named as primary beneficiary in the employee's or retirement system member's will;
- (7) the same-sex partner has authority to deal with property owned by the employee or retirement system member under a valid written power of attorney;
- (8) the employee or retirement system member has given the same-sex partner written authority to make decisions concerning the employee's or retirement system member's health and well being if the employee or retirement system member is unable to do so.

(d) An employee or member of a state retirement system who enrolls a same-sex partner in coverage under this section may also enroll the child of the same-sex partner if the child is unmarried, is dependent on the employee or retirement system member for support, and meets other requirements set out in the group policy, state plan of self-insurance, or alternative insurance program, and applicable statute governing the retirement system, including age and applicable school enrollment requirements.

(e) An employee or member of a state retirement system who has enrolled a same-sex partner, or a same-sex partner and child, in coverage under this section shall provide written confirmation of eligibility of the enrolled person, supplementing documentation provided under (c) of this section if that information has changed, upon request of and in the manner requested by the plan administrator. Failure to provide written confirmation requested by the plan administrator may result in suspension of coverage of the enrolled person.

(f) An employee or retirement system member who enrolls a same-sex partner in coverage under this section must agree that, if the employee or retirement system member and same-sex partner no longer meet the requirements of this section, the employee or retirement system member will file with the administrator of each plan in which the same-sex partner is enrolled a written statement of termination of eligibility within 30 days of the date that eligibility ends. Eligibility of the same-sex partner for benefits of a plan terminates on midnight of the date that eligibility ends as declared in writing by the employee or retirement system member. Failure to notify the plan administrator of termination of eligibility results in liability of the employee or retirement system member for any resulting overpayment of benefits under the plan. Continuation of coverage will be offered to the former same-sex partner of the employee or retirement system member as if a divorce had occurred.

(g) An employee or retirement system member who enrolls a same-sex partner, or same-sex partner and eligible child under (d) of this section, in coverage under this section shall pay any premium established by the plan that an employee or retirement system member is required to pay for comparable coverage for a spouse or spouse and dependent child.

(h) In this section, "resided together at a common primary residence" requires the employee or member of a state retirement system and the employee's or member's same-sex partner to share the same domicile. The common primary residence can change during the 12-month period set out in (b) of this section. Once an employee or member of a state retirement system and same-sex partner have begun to reside together at a common primary residence, absence by the employee or retirement system member or the same-sex partner required for employment that requires periodic absence from the common primary residence, education, medical reasons, military service, or other reasons determined by the plan administrator will not result in a break in eligibility, as long as the absent employee, retirement system member, or same-sex partner intends to return to common primary residence. (Eff. 11/12/2006, Register _____; am ____/____/____, Register _____)

Authority: AS 14.25.005 AS 39.30.090 Former AS 39.37.090
AS 22.25.027 AS 39.35.005

2 AAC 38.030. Enrollment of same-sex partner and same-sex partner's eligible child. (a) After November 12, 2006, a special enrollment will be conducted to allow enrollment of eligible same-sex partners and eligible children of same-sex partners in group insurance plans described in 2 AAC 38.010(a). If the terms of a group insurance plan described in 2 AAC 38.010(a) allow enrollment of a spouse or family at only a specific time, such as the date of retirement of a member of the retirement system, in order to enroll a same-sex partner or child of a same-sex partner in the plan during the special enrollment, the employee or member of a state retirement system must establish that the requirements of 2 AAC 38.010(b) and (c) were met at the time specified by the terms of the plan.

(b) Following the special enrollment, enrollment of a same-sex partner or child of a same-sex partner may occur only at a subsequent open enrollment or upon the occurrence of a qualifying status change and in accordance with the terms of the plan. For purposes of a plan described in 2 AAC 38.010(a) that allows an employee or member of a state retirement system to enroll a spouse or dependent child within a period of time after

a qualifying status change occurs, such as a change in family structure, ineligibility for other coverage or change in insurance coverage, a qualifying status change for enrollment of the employee's or retirement system member's same-sex partner or eligible children of a same-sex partner occurs on the date upon which

(1) the employee or retirement system member is first able to meet the requirements of 2 AAC 38.010(b) and (c), if the plan allows enrollment of a spouse and eligible dependent children when a plan member marries;

(2) a status change occurs related to the same-sex partner that would constitute a qualifying status change event under the terms of the plan if the status change related to the spouse of the employee or retirement system member.

(c) The employee or retirement system member should provide the documentation required by 2 AAC 38.010(c) within 90 days of filing an enrollment form with the administrator of a plan under AS 39.30.090 or 39.30.091, or if the enrollment is filed with the administrator of an alternative insurance program under AS 39.30.090(a)(2), within the time provided by the alternative insurance program plan. Once the documentation required under 2 AAC 38.010(c) is received by the administrator of a plan under AS 39.30.090 or 39.30.091, coverage of the eligible same-sex partner is effective on the latest of the first day of the month after the enrollment form is received by the plan administrator, the date of the employee's appointment to receive retirement or disability benefits if the enrollment is for a retiree insurance plan, the date coverage is allowed under the terms of an open enrollment if the enrollment is filed under the open enrollment, or January 1, 2007. Payment will not be made on covered claims until eligibility is established under 2 AAC 38.010. Payment will not be made on claims arising more than 12 months before eligibility is established under 2 AAC 38.010.

(d) This section does not authorize or require a change in type or level of coverage if such a change is not allowed by federal regulations governing mid-year changes in coverage or under the provisions of the plan, nor does this section prohibit mid-year changes in the type or level of coverage if such change is required by federal regulations or permitted under the provisions of the plan. Changes in the type or level of coverage may be made during any regular open enrollment period of the plan, if allowed by federal regulations governing the plan.

(e) To the extent permitted by federal regulations, a same-sex partner and an eligible child of a same-sex partner will be considered dependents under the plan for purposes of eligibility, including continuation of coverage and 29 U.S.C. 1182 (Health Care Portability and Accountability Act of 1996) (HIPAA) portability rights, even if the individual does not qualify as a dependent for federal tax purposes. (Eff. 11/12/2006, Register _____; am ____/____/____, Register _____)

Authority: AS 14.25.005 AS 39.30.090 Former AS 39.37.090
AS 22.25.027 AS 39.35.005

2 AAC 38.050. Imputation of income and effect on pre-tax premiums. (a) Income will be imputed for federal tax purposes to

(1) an employee or member of a state retirement system who enrolls a same-sex partner or child of a same-sex partner who is not an eligible dependent under 26 U.S.C. 152, without regard to 26 U.S.C. 152(b)(1), (b)(2) and (d)(1)(B), in group insurance coverage under 2 AAC 38.010;

(2) a same-sex partner of a member of a state retirement system if the same-sex partner was not an eligible dependent of the member under 26 U.S.C. 152, without regard to 26 U.S.C. 152(b)(1), (b)(2), and (d)(1)(B), at the time of the member's death and if the same-sex partner is enrolled in group insurance coverage as a survivor of the member under 2 AAC 38.010.

(b) The amount of income imputed to an employee, retirement system member, or survivor under this section will be based on the fair market value of the coverage provided to the non-dependent same-sex partner as established by the administrator of the state's employee and retiree health plans. The fair market value of coverage provided by a union health trust under an alternative insurance program under an exemption allowed by regulations adopted by the commissioner under AS 39.30.090(a)(2) will be established in consultation with the applicable trust.

(c) If an employee's premium payment for group insurance coverage of a same-sex partner or child of a same-sex partner is not eligible for pre-tax treatment, the premium payment will be deducted on a post-tax basis in the amount established by the administrator of the applicable plan.

(d) Income imputed under this section does not constitute compensation for purposes of determining employer or employee contributions or computation of benefits under the state's retirement systems or Alaska Supplemental Annuity Plan. (Eff. 11/12/2006, Register _____; am ____/____/____, Register _____)

Authority: AS 14.25.005 AS 39.30.090 Former AS 39.37.090
AS 22.25.027 AS 39.35.005

2 AAC 38.070. Same-sex partner survivor benefits.

(a) A state employee or member of a state retirement system may designate the employee's or retirement system member's same-sex partner as the beneficiary to receive survivor benefits that are available to an employee's or retirement system member's surviving spouse in accordance with this section. Survivor benefits are payable to a same-sex partner designated under this section to the extent the benefits are not payable to a former spouse under the terms of a qualified domestic relations order.

(b) A designation of a same-sex partner to receive survivor benefits that may be paid to a person other than a spouse under applicable statute is valid to the same extent the designation of any other non-spouse beneficiary is valid under the statute.

(c) A designation by a member of a state retirement system of a same-sex partner as beneficiary to receive survivor benefits that are available to a surviving spouse under AS 14.25.155, 14.25.157, 14.25.160, 14.25.162, 14.25.164, 14.25.167, 14.25.420, 14.25.485, 14.25.487; AS 22.25.030; AS 39.35.420, 39.35.430, 39.35.440, 39.35.450, 39.35.890, 39.35.892; or former AS 39.37.060 is not valid unless the member files with the administrator

(1) with the designation of beneficiary an affidavit executed by the member and the same-sex partner making the declarations, under penalty of perjury, set out in 2 AAC 38.010(b); and

(2) documentation establishing that the member and same-sex partner meet at least five of the criteria set out in 2 AAC 38.010(c).

(d) A deceased employee's or retirement system member's same-sex partner whom the administrator determines is validly designated as the employee's or member's beneficiary to receive survivor benefits has the same rights to survivor

benefits, including group insurance and alternative insurance benefits available under the applicable plan, that a surviving spouse would have, and is subject to the same requirements that a surviving spouse would be subject to relating to those benefits.

(e) An employee or member of a state retirement system may revoke a designation of beneficiary under this section at any time. After the date of retirement, a member's revocation of the designation of the member's same-sex partner as the beneficiary to receive survivor benefits does not change the form or amount of a joint and survivor benefit payable to the member or allow designation of a different beneficiary to receive the joint and survivor benefit.

(f) An employee or member of a state retirement system who has designated a same-sex partner as beneficiary under this section shall provide written confirmation of the designation, supplementing documentation provided under (c) of this section if that information has changed, upon request of and in the manner requested by the plan administrator. Failure to provide written confirmation requested by the plan administrator may result in ineligibility of the designated same-sex partner for survivor benefits. (Eff. 11/12/2006, Register _____; am ____/____/____, Register _____)

Authority: AS 14.25.005 AS 39.35.005 Former AS 39.37.090
AS 22.25.027

2 AAC 38.100. Responsibilities and rights of a state employee or member of a state retirement system and same-sex partner.

(a) It is the responsibility of a state employee or member of a state retirement system to comply with all requirements of an insurance, retirement, or benefit plan or program, including all application, designation, affidavit, and documentation requirements, in order to provide or allow provision of benefits to the employee's or retirement system member's same-sex partner. Except when specifically provided by this chapter or the terms of an insurance, retirement, or benefit plan or program, an employee's or retirement system member's compliance with the application, affidavit, and documentation requirements of a plan or program does not entitle the employee's or retirement system member's same-sex partner to rights or benefits under a different plan or program.

(b) Nothing in this chapter supersedes the requirements of a court order regarding rights or benefits of a former spouse or dependents of an employee or retirement system member.

(c) Nothing in this chapter provides, or allows the provision of, any right or benefit to the same-sex partner of an employee or retirement system member that would not be available to the spouse of the employee or retirement system member. (Eff. 11/12/2006, Register _____; am ____/____/____, Register _____)

Authority: AS 14.25.005 AS 39.30.090 Former AS 39.37.090
AS 22.25.027 AS 39.35.005

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Division of Retirement and Benefits**

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