**Benefit Options**
Choice. Value. Health.

# STATE OF ARIZONA ACTIVE 2010 SPECIAL ENROLLMENT FORM

**August 16 through September 15, 2010**

| DATE RECEIVED | AGENCY | EFFECTIVE DATE |
|---|---|---|
| | | |

## EMPLOYEE IDENTIFICATION

| LAST NAME, FIRST NAME, M.I. | EMPLOYEE EIN or SSN | ☐ MALE ☐ FEMALE |
|---|---|---|
| STREET ADDRESS | COUNTY OF RESIDENCE | DATE OF BIRTH |
| CITY, STATE, ZIP CODE | WORK PHONE NUMBER | HOME PHONE NUMBER |

## MEDICAL PLANS (Employee Monthly Cost Listed)

☐ I DECLINE MEDICAL COVERAGE ☐ I ELECT TO KEEP MY CURRENT MEDICAL COVERAGE

| SELECT A PLAN | CODE | EE ONLY | CODE | EE + ADULT | CODE | EE + CHILD | CODE | EE + FAMILY |
|---|---|---|---|---|---|---|---|---|
| **EPO PLANS** | | | | | | | | |
| CIGNA EPO | | ☐ $39.00 | | ☐ $97.00 | | ☐ $79.00 | | ☐ $178.00 |
| AMERIBEN EPO | | ☐ $39.00 | | ☐ $97.00 | | ☐ $79.00 | | ☐ $178.00 |
| AETNA EPO | | ☐ $39.00 | | ☐ $97.00 | | ☐ $79.00 | | ☐ $178.00 |
| UNITEDHEALTHCARE EPO | | ☐ $39.00 | | ☐ $97.00 | | ☐ $79.00 | | ☐ $178.00 |
| **PPO PLANS** | | | | | | | | |
| AMERIBEN PPO | | ☐ $154.00 | | ☐ $328.00 | | ☐ $309.00 | | ☐ $443.00 |
| AETNA PPO | | ☐ $154.00 | | ☐ $328.00 | | ☐ $309.00 | | ☐ $443.00 |
| UNITEDHEALTHCARE PPO | | ☐ $154.00 | | ☐ $328.00 | | ☐ $309.00 | | ☐ $443.00 |
| **HSA OPTION** | | | | | | | | |
| AETNA HSA | | ☐ $25.00 | | ☐ $80.00 | | ☐ $59.00 | | ☐ $150.00 |

## DENTAL PLANS (Employee Monthly Cost Listed)

☐ I DECLINE DENTAL COVERAGE ☐ I ELECT TO KEEP MY CURRENT DENTAL COVERAGE

| SELECT A PLAN | CODE | EE ONLY | CODE | EE + ONE | CODE | EE + FAMILY |
|---|---|---|---|---|---|---|
| TOTAL DENTAL ADMINISTRATORS | | ☐ $5.00 | | ☐ $9.00 | | ☐ $14.00 |
| DELTA DENTAL INDEMNITY/PPO | | ☐ $29.86 | | ☐ $67.93 | | ☐ $118.12 |

## VISION PLAN (Employee Monthly Cost Listed)

☐ I DECLINE VISION COVERAGE ☐ I ELECT TO KEEP MY CURRENT VISION COVERAGE

| SELECT A PLAN | CODE | EE ONLY | CODE | EE + ONE | CODE | EE + FAMILY |
|---|---|---|---|---|---|---|
| AVESIS VISION COVERAGE | | ☐ $4.83 | | ☐ $13.52 | | ☐ $16.86 |

**Effective January 1, 2009, all Active State employees will be required to provide social security numbers (SSNs) for their enrolled dependents.**

The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that the Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for coordination of benefit purposes.

**REVISED 07/27/10**

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# STATE OF ARIZONA ACTIVE
# 2010 SPECIAL ENROLLMENT FORM CONTINUED

**DEPENDENTS -** List all eligible dependents to be enrolled in medical, dental, and/or vision plans

| LAST NAME, FIRST NAME, M.I. (USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS) | Date of Birth (MM/DD/YY) | Social Security Number | RELATIONSHIP CODE | MALE OR FEMALE | ADD OR DELETE | Indicate Plan Type Medical(M) Dental(D) Vision(V) |
|---|---|---|---|---|---|---|
| **LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER** | **REQUIRED** | **REQUIRED** | | | A OR D | |
| **Employee** | | | S- Spouse<br>C- Child<br>D- Domestic Partner<br>G- Guardian<br>P- Placed for adoption<br>T- Stepchild | | | |
| **Spouse or Domestic Partner** | | | ☐ S ☐ D | ☐ M ☐ F | | ☐ M ☐ D ☐ V |
| | | | ☐ C ☐ G ☐ P ☐ T | ☐ M ☐ F | | ☐ M ☐ D ☐ V |
| | | | ☐ C ☐ G ☐ P ☐ T | ☐ M ☐ F | | ☐ M ☐ D ☐ V |
| | | | ☐ C ☐ G ☐ P ☐ T | ☐ M ☐ F | | ☐ M ☐ D ☐ V |
| | | | ☐ C ☐ G ☐ P ☐ T | ☐ M ☐ F | | ☐ M ☐ D ☐ V |
| | | | ☐ C ☐ G ☐ P ☐ T | ☐ M ☐ F | | ☐ M ☐ D ☐ V |

## SHORT-TERM DISABILITY

**The Hartford Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay $0.70 for every $100 of earned income per month. Please visit www.benefitoptions.az.gov for more information regarding Short-Term Disability coverage.**

☐ **I DECLINE SHORT-TERM DISABILITY** ☐ **I ELECT SHORT-TERM DISABILITY**

## SUPPLEMENTAL LIFE INSURANCE

**Supplemental coverage is available in increments of $5,000. Your cost for Supplemental Life and AD&D insurance is based on your age as of January 1st (the first day of the plan year). Premiums for Supplemental Life coverage above $35,000 are paid on an after-tax basis. You may elect to increase your Supplemental Life coverage during Open Enrollment.**

☐ **I DECLINE SUPPLEMENTAL LIFE INSURANCE** ☐ **I ELECT TO KEEP MY CURRENT SUPPLEMENTAL LIFE INSURANCE**

**Total amount of employee coverage: $_____**

## DEPENDENT LIFE INSURANCE

☐ **I DECLINE DEPENDENT LIFE INSURANCE** ☐ **I ELECT TO KEEP MY CURRENT DEPENDENT LIFE INSURANCE**

| | | | | | |
|---|---|---|---|---|---|
| ☐ **$2,000** | **$0.94/MONTH** | **Plan Code 02** | ☐ **$12,000** | **$5.64/MONTH** | **Plan Code 12** |
| ☐ **$4,000** | **$1.88/MONTH** | **Plan Code 04** | ☐ **$15,000** | **$7.05/MONTH** | **Plan Code 15** |
| ☐ **$6,000** | **$2.82/MONTH** | **Plan Code 06** | ☐ **$50,000** | **$24.25/MONTH** | **Plan Code 50** |

| Beneficiary Last Name, First Name | Date of Birth |
|---|---|
| Beneficiary Street, City, State, Zip Code | |

**EMPLOYEE AUTHORIZATION AND SIGNATURE**

**I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/domestic partner and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In addition, I have read and understand the declarations.**

**SIGNATURE:**_____ **DATE:**_____

**Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 Or fax to: 602-542-4744**

**REVISED 07/27/10**

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Print Form