

2012 ENROLLMENT / CHANGE FORM

NEW ENROLLMENT
 QUALIFIED LIFE EVENT
 ADDRESS CHANGE
 TERMINATION

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE
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MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.		SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED
			<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE
STREET ADDRESS		COUNTY OF RESIDENCE	DATE OF BIRTH	
CITY, STATE, ZIP CODE		WORK PHONE NUMBER ()	HOME PHONE NUMBER ()	
EMPLOYEE LAST NAME, FIRST NAME	EMPLOYEE AGENCY	EMPLOYEE EIN OR SSN		

Are you enrolling a Same-Sex Domestic Partner?(circle one) Yes or No

To qualify a Same-Sex Domestic Partner for the first time, you will need to complete and submit the **SAME-SEX DOMESTIC PARTNER AFFIDAVIT FORM** (this form must be notarized) with your enrollment. This form can be found on the Benefit Options website www.benefitoptions.az.gov.

MEDICAL PLANS* (Monthly Cost Listed)

I DECLINE MEDICAL COVERAGE OR

EPO PLANS

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
AETNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
BCBS of AZ/AMERIBEN EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
CIGNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52

PPO PLANS

AETNA PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
BCBS of AZ/AMERIBEN PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30

HSA OPTION

AETNA HSA OPTION		<input type="checkbox"/> \$539.58		<input type="checkbox"/> \$1134.24		<input type="checkbox"/> \$1079.16		<input type="checkbox"/> \$1487.16
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*For the NAU Blue Cross Blue Shield plan rates visit: <http://hr.nau.edu/m/content/view/102/112/>.

DENTAL PLANS (Monthly Cost Listed)

I DECLINE DENTAL COVERAGE OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$10.16		<input type="checkbox"/> \$19.30		<input type="checkbox"/> \$28.25
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$36.66		<input type="checkbox"/> \$82.41		<input type="checkbox"/> \$139.56

VISION PLAN (Monthly Cost Listed)

I DECLINE VISION COVERAGE OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$4.93		<input type="checkbox"/> \$13.79		<input type="checkbox"/> \$17.20

ADOA USE ONLY

APPROVED
 DENIED

COBRA EFF: _____

Length of COBRA: _____

Vendors: _____

Date to Vendors: _____

Reviewed by: _____

2012 COBRA ENROLLMENT FORM

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YOUR PAYMENT TO BENEFIT OPTIONS

By law, while on COBRA coverage, you will have to pay the total cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families – both the employee's and the employer's portion - plus an additional 2% administrative fee. You must make the first payment within 45 days of notifying the plan administrator of selection of COBRA coverage. The initial payment with your enrollment needs to be sent to ADOA. Thereafter, premiums are due on the first day of each month of coverage. After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums.

Effective January 1, 2009, Social Security numbers (SSN) will be required for you and your 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.

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

LAST NAME, FIRST NAME, M.I. <small>(USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)</small>	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	REQUIRED	REQUIRED			A OR D	
Employee			S- Spouse C- Child D- Same-Sex Domestic Partner G- Guardian P- Placed for adoption T- Stepchild			
Spouse or Same-Sex Domestic Partner			<input type="checkbox"/> S <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify 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

2012 COBRA ENROLLMENT FORM