

NEW ENROLLMENT    QUALIFIED LIFE EVENT    ADDRESS CHANGE    TERMINATION

**MEMBER IDENTIFICATION**

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

**MEDICAL PLANS\* (Monthly Cost Listed)**

I DECLINE MEDICAL COVERAGE

**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

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$9.17		<input type="checkbox"/> \$18.34		<input type="checkbox"/> \$17.86		<input type="checkbox"/> \$27.51
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$36.66		<input type="checkbox"/> \$ 77.14		<input type="checkbox"/> \$61.69		<input type="checkbox"/> \$120.63

**VISION PLAN (Monthly Cost Listed)**

I DECLINE VISION COVERAGE

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: \_\_\_\_\_

Reviewed by:

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE
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**2013 COBRA ENROLLMENT FORM**

**2013 ENROLLMENT / CHANGE FORM**

**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 provided in this application for health benefits is correct and true. I am aware that providing false information - including that which is related to my address, spouse, or dependent(s) - may subject me to denial of health benefits, disciplinary action, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACT).

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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

**2013 COBRA ENROLLMENT FORM**