Benefit Options
Choice Value Health

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD 2014 ENROLLMENT FORM

☐ NEW RETIREE ☐ NEW LTD PARTICIPANT ☐ ADDRESS CHANGE

☐ QUALIFIED LIFE EVENT ☐ TERMINATE INSURANCE ☐ OPEN ENROLLMENT

☐ RETIRED ☐ DISABLED ☐ SURVIVING SPOUSE	Retirement System ☐ ASRS (ZA) ☐ PSPRS, CORP, EORP (ZP) ☐ OPTIONAL (ZT)	
EFFECTIVE DATE:	**DECEASED MEMBER'S NAME:**	**DECEASED DATE:**

MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	DATE OF BIRTH
STREET ADDRESS (NO P.O.BOX)		COUNTY OF RESIDENCE		
CITY, STATE, ZIP CODE	E-MAIL ADDRESS (Mandatory)			
LAST DAY WORKED	DATE RETIRED	**MEDICARE** ☐ YES ☐ NO	HOME PHONE NUMBER ( )	AGENCY

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 DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized). This form can be found on the Benefit Options website at *www.benefitoptions.az.gov*.

DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH *(Required)*	RELATIONSHIP CODE S=Spouse D=Same-Sex Domestic Partner C=Child G=Guardian P=Placed for adoption T=Stepchild	MEDICARE A=Medicare A B=Medicare B C=Medicare A & B D=Medicare Unknown E=No Medicare	SOCIAL SECURITY NUMBER *(Required)*	MALE OR FEMALE M OR F	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
MEMBER:							☐ M ☐ D ☐ V
SPOUSE OR SAME-SEX DOMESTIC PARTNER:							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V

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VISION PLAN SELECTION **- ONLY AVAILABLE IF MEDICAL AND/OR DENTAL COVERAGE IS SELECTED**

VISION PLAN - MONTHLY PREMIUMS AMOUNT

☐ **DECLINE VISION COVERAGE**

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
Avesis	☐ $4.83	☐ $13.52	☐ $16.86

DENTAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ **DECLINE DENTAL COVERAGE**

Select A Plan	Retiree Only	Retiree + Adult	Retiree + Child	Retiree & Family
Delta Dental PPO Plus Premier	☐ $35.94	☐ $75.63	☐ $60.48	☐ $118.26
Total Dental Administrators	☐ $8.99	☐ $17.98	☐ $17.51	☐ $26.97

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ **DECLINE MEDICAL COVERAGE**

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
NON MEDICARE EPO PLANS			
AETNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
BCBSAZ/AMERIBEN EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
CIGNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
UNITEDHEALTHCARE EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
NON MEDICARE PPO PLANS			
AETNA PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
BCBSAZ/AMERIBEN PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
UNITEDHEALTHCARE PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
NAU Only - Available in ALL regions NON MEDICARE			
BCBS of Arizona PPO	☐ $667.06	☐ $1334.12	☐ $1867.79

****BENEFIT SERVICES DIVISION USE ONLY****

PLAN NAME: _____ **PLAN OPTION CODE:**_____

****FOR MEMBERS WITH MEDICARE, MAKE MEDICAL ENROLLMENT SELECTIONS ON THE FOLLOWING PAGE****

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FOR MEMBERS WITH MEDICARE - You are required to complete the 2014 Group Part D Prescription Drug Enrollment Form

☐ I HAVE MEDICARE PART A	☐ I HAVE MEDICARE PART B

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT - MEDICARE OPTIONS

☐ **ACCEPT MEDICAL COVERAGE - Medicare becomes primary for medical coverage and includes Medicare Part D prescription drug coverage. I understand that if I lose my prescription drug coverage, I will also lose my medical coverage.**

☐ **DECLINE MEDICAL COVERAGE**

Select A Plan	Retiree Only with Medicare	Retiree + ONE: Both with Medicare	Retiree + ONE: One with Medicare, the other without	Retiree & Family With Medicare
EPO PLANS				
AETNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
BCBSAZ/AMERIBEN EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
CIGNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
UNITEDHEALTHCARE EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
PPO PLANS				
AETNA PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
BCBSAZ/AMERIBEN PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
UNITEDHEALTHCARE PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
NAU Only - Available in ALL Regions				
BCBS of Arizona PPO	☐ $543.06	☐ $1086.39	☐ $1210.12	☐ $1492.95

1. If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future.
2. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.
3. If you are eligible for Medicare, your medical coverage will include prescription drug coverage in a Medicare Part D plan with additional coverage provided by the State of Arizona.
4. If you are enrolled in another Medicare prescription drug plan or individual Medicare Advantage plan – with or without prescription drug coverage – you will be disenrolled from that coverage. If you enroll in these plans after you are enrolled in the State of Arizona's plan, you will be disenrolled from the State of Arizona plan.
5. If you are disenrolled or otherwise leave the State of Arizona prescription drug plan, you will lose both your medical and prescription drug coverage.

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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:** _____

For members with Medicare, a 2014 Group Participation Part D Prescription Drug Enrollment Form for the State of Arizona Benefit Options Program is required to be signed for each Medicare participant, for retiree+one; two additional forms should be submitted with this enrollment form.

Return form to: ADOA, Human Resources Division, Benefit Services, 100 N. 15th Ave., Suite 103 Phoenix, AZ 85007 or Fax 602-542-4744

***** BENEFIT SERVICES DIVISION USE ONLY *****

PLAN NAME: _____	**PLAN OPTION CODE:** _____