



STATE OF ARIZONA ACTIVE 2015 OPEN ENROLLMENT FORM

IMPORTANT! Enrollment should be completed online at yes.az.gov. This form should only be used if you are unable to access Y.E.S.

DATE RECEIVED

AGENCY

EFFECTIVE DATE

OPEN ENROLLMENT NEW EMPLOYEE QUALIFIED LIFE EVENT ADDRESS CHANGE TERMINATION

EMPLOYEE IDENTIFICATION

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

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.

Employee Per Pay Period Cost Listed (26 Pay Periods)

MEDICAL PLANS

I DECLINE MEDICAL COVERAGE

EPO PLANS

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
CIGNA EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102.00
BCBS AZ EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102.00
AETNA EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102.00
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102.00

PPO PLANS

BCBS AZ PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31
AETNA PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31

HSA OPTION

AETNA HSA		<input type="checkbox"/> \$12.00		<input type="checkbox"/> \$47.08		<input type="checkbox"/> \$37.38		<input type="checkbox"/> \$89.08
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DENTAL PLANS

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"/> \$1.86		<input type="checkbox"/> \$3.72		<input type="checkbox"/> \$3.50		<input type="checkbox"/> \$6.12
DELTA DENTAL INDEMNITY/PPO		<input type="checkbox"/> \$14.30		<input type="checkbox"/> \$30.33		<input type="checkbox"/> \$23.34		<input type="checkbox"/> \$48.26

VISION PLAN

I DECLINE VISION COVERAGE

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$1.84		<input type="checkbox"/> \$5.97		<input type="checkbox"/> \$5.89		<input type="checkbox"/> \$7.43

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.

2015 OPEN ENROLLMENT FORM



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DEPENDENTS - List all eligible dependents to be enrolled 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 MEMBER	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

Employee Per Pay Period Cost Listed (26 Pay Periods)

SHORT-TERM DISABILITY

The Hartford Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay \$0.65 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). The maximum amount for Supplemental Life is 3 times your salary up to \$500,000. 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 SUPPLEMENTAL LIFE INSURANCE Total amount of employee coverage: \$ _____

DEPENDENT LIFE INSURANCE

I DECLINE DEPENDENT LIFE INSURANCE

<input type="checkbox"/> \$2,000	\$0.43	Plan Code 02	<input type="checkbox"/> \$12,000	\$2.60	Plan Code 12
<input type="checkbox"/> \$4,000	\$0.87	Plan Code 04	<input type="checkbox"/> \$15,000	\$3.25	Plan Code 15
<input type="checkbox"/> \$6,000	\$1.30	Plan Code 06	<input type="checkbox"/> \$50,000*	\$10.85	Plan Code 50
<input type="checkbox"/> \$10,000	\$2.17	Plan Code 10	*To qualify for \$50,000 you must elect a minimum of \$35,000 in Supplemental Life Insurance.		

Beneficiary Last Name, First Name	Beneficiary Date of Birth	Beneficiary SSN	Beneficiary Contact Number
Beneficiary Street, City, State, Zip Code			

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. I authorize my employer to reduce my salary by applicable pre-tax dollars or reduce my paycheck by the applicable after-tax dollars for the insurance programs which I have elected. In addition, I have read and understand the declarations. 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 Human Resources Division- Benefit Services , 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 or
fax to: 602-542-4744 or email to: benefitissues@azdoa.gov.

2015 OPEN ENROLLMENT FORM

STATE OF ARIZONA SUPPLEMENTAL FORM FOR BENEFICIARIES AND DEPENDENTS

IMPORTANT! Enrollment should be completed online at yes.az.gov. This form should only be used if you are unable to access Y.E.S.

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME		EMPLOYEE ID NUMBER	DATE OF EMPLOYMENT
STREET ADDRESS		CITY, STATE	ZIP CODE
HOME TELEPHONE	WORK TELEPHONE	AGENCY NAME	AGENCY CODE

ADDITIONAL BENEFICIARIES

01 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C	% OF FUNDS	SSN	PHONE NUMBER
02 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C	% OF FUNDS	SSN	PHONE NUMBER
03 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C	% OF FUNDS	SSN	PHONE NUMBER
04 LAST NAME, FIRST NAME	STREET ADDRESS	CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY <input type="checkbox"/> P <input type="checkbox"/> C	% OF FUNDS	SSN	PHONE NUMBER

TRUST OR LEGAL AGREEMENT

NAME OF TRUST, WILL OR LEGAL AGREEMENT

ADDRESS WHERE FILED	CITY, STATE	ZIP CODE
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DATE OF TRUST	
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ADDITIONAL DEPENDENTS

LAST NAME, FIRST NAME	MEDICARE A= Medicare A B= Medicare B C=Medicare A&B D= No Medicare E=Medicare Unknown	SSN	BIRTH DATE	RELATIONSHIP C=Child G=Guardian P=Placed for adoption T=Stepchild	MALE OR FEMALE <input type="checkbox"/> M <input type="checkbox"/> F	DISABLED <input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including spouse/dependent information is true and correct. 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 13-2310, 12-2702 and other applicable provisions of the law.

EMPLOYEE SIGNATURE: _____ **DATE:** _____