Benefit Options
Choice Value Health
ADOA-HRD

STATE OF ARIZONA
2015 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 □ P □ C	% OF FUNDS	SSN	PHONE NUMBER	
02 LAST NAME, FIRST NAME	STREET ADDRESS		CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY □ P □ C	% OF FUNDS	SSN	PHONE NUMBER	
03 LAST NAME, FIRST NAME	STREET ADDRESS		CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY □ P □ C	% OF FUNDS	SSN	PHONE NUMBER	
04 LAST NAME, FIRST NAME	STREET ADDRESS		CITY, STATE	ZIP CODE
PRIMARY BENEFICIARY OR CONTINGENT BENEFICIARY □ P □ C	% OF FUNDS	SSN	PHONE NUMBER	

TRUST OR LEGAL AGREEMENT

NAME OF TRUST, WILL OR LEGAL AGREEMENT

ADDRESS WHERE FILED	CITY, STATE	ZIP CODE
DATE OF TRUST		

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	DISABLED
					□ M □ F	□ Y □ N
					□ M □ F	□ Y □ N
					□ M □ F	□ Y □ N
					□ M □ F	□ Y □ N
					□ M □ F	□ Y □ 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:**_____

Revised 10/07/14