

2016 Benefit Options Open Enrollment Form - Retiree



INSURED INFORMATION						
REQUIRED Insured Information	Name- Last		First		MI	
	EIN or SSN		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Agency	
Address	Street			City	State	Zip
Contact Information	Home Phone		Cell Phone	Email	County	

REQUIRED	<p>Select all that apply:</p> <p><input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s)</p> <p><input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change</p>
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SPOUSE/DEPENDENT INFORMATION FOR RELATIONSHIP INDICATE <u>SPOUSE</u> , <u>CHILD</u> , <u>STEPCHILD</u> , <u>PLACED FOR ADOPTION</u> , OR <u>GUARDIAN</u> .						
For Changes Only	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP	MEDICAL (M) DENTAL (D) VISION (V)
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V

Vision Plan - Monthly Premiums Amount (Only Available if Medical and/or Dental Coverage is Selected)		
Action	Provider	Coverage Level
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> Avesis Vision Coverage	<input type="checkbox"/> Retiree Only (\$3.00) <input type="checkbox"/> Retiree + One (\$12.94) <input type="checkbox"/> Retiree + Child (\$12.76) <input type="checkbox"/> Retiree & Family (\$16.10)

Dental Plan - Monthly Premiums Amount		
Action	Provider	Coverage Level
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> Total Dental Administrators	<input type="checkbox"/> Retiree Only (\$8.99) <input type="checkbox"/> Retiree + One (\$17.98) <input type="checkbox"/> Retiree + Child (\$17.51) <input type="checkbox"/> Retiree & Family (\$26.97)
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> Delta Dental PPO Plus Premier	<input type="checkbox"/> Retiree Only (\$35.94) <input type="checkbox"/> Retiree + One (\$75.63) <input type="checkbox"/> Retiree + Child (\$60.48) <input type="checkbox"/> Retiree & Family (\$118.26)

Medical Plan - Monthly Premiums Amount * (NON-MEDICARE) *****

Action	Plan Type	Provider	Coverage Level
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> EPO	<input type="checkbox"/> Cigna <input type="checkbox"/> United HealthCare <input type="checkbox"/> BCBSAZ <input type="checkbox"/> Aetna	<input type="checkbox"/> Retiree Only (\$593.00) <input type="checkbox"/> Retiree + One (\$1,387.00) <input type="checkbox"/> Retiree & Family (\$1,869.00)
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> PPO	<input type="checkbox"/> United HealthCare <input type="checkbox"/> BCBSAZ <input type="checkbox"/> Aetna	<input type="checkbox"/> Retiree Only (\$825.00) <input type="checkbox"/> Retiree + One (\$2,009) <input type="checkbox"/> Retiree & Family (\$2,197)
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> PPO - NAU ONLY	<input type="checkbox"/> BCBSAZ	<input type="checkbox"/> Retiree Only (\$739.79) <input type="checkbox"/> Retiree + One (\$1,461.57) <input type="checkbox"/> Retiree & Family (\$2,046.23)

For Members with Medicare - You are required to complete the 2016 Group Part D Prescription Drug Enrollment Form (Enclosed)

<input type="checkbox"/> I Have Medicare Part A	<input type="checkbox"/> I Have Medicare Part B
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I ACCEPT MEDICAL AND PHARMACY COVERAGE - Medicare becomes your primary insurance for medical coverage and includes Medicare Part D prescription drug coverage. I also understand that if I enroll in another Part D Prescription Drug Program I will lose both my prescription drug coverage and my medical coverage.

I DECLINE MEDICAL AND PHARMACY COVERAGE

Medical Plan - Monthly Premiums Amount * (MEDICARE) *****

Action	Plan Type	Provider	Coverage Level
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> EPO	<input type="checkbox"/> Cigna <input type="checkbox"/> United HealthCare <input type="checkbox"/> BCBSAZ <input type="checkbox"/> Aetna	<input type="checkbox"/> Retiree Only (\$442.00) <input type="checkbox"/> Retiree + One: Both with Medicare (\$878.00) <input type="checkbox"/> Retiree + One: One with Medicare, the other without (\$1,024.00) <input type="checkbox"/> Retiree & Family with Medicare (\$1,166.00)
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> PPO	<input type="checkbox"/> United HealthCare <input type="checkbox"/> BCBSAZ <input type="checkbox"/> Aetna	<input type="checkbox"/> Retiree Only (\$789.00) <input type="checkbox"/> Retiree + One: Both with Medicare (\$1,576.00) <input type="checkbox"/> Retiree + One: One with Medicare, the other without (\$1,740.00) <input type="checkbox"/> Retiree & Family with Medicare (\$1,980.00)
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> PPO NAU ONLY	<input type="checkbox"/> BCBSAZ	<input type="checkbox"/> Retiree Only (\$594.94) <input type="checkbox"/> Retiree + One: Both with Medicare (\$1,190.02) <input type="checkbox"/> Retiree + One: One with Medicare, the other without (\$1,325.73) <input type="checkbox"/> Retiree & Family with Medicare (\$1,635.58)

1. 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.
2. If you are enrolled in another Medicare prescription drug plan or individual Medicare Advantage plan – with or without prescription drug coverage – you will automatically 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.
3. If you are disenrolled or otherwise leave the State of Arizona medical or prescription drug plan, you will lose both your medical and prescription drug coverage.

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 (ACA).

Member Signature: _____ Date: _____

Dependent/Spouse Signature: _____ Date: _____

**Return form to: ADOA, Benefit Services Division, 100 N. 15th Ave., Suite 103
Phoenix, AZ 85007 or fax: 602-542-4744 or email to: benefitsissues@azdoa.gov.**

