2016 Benefit Options Open Enrollment Form - Active Employee

Arizona Department of Administration
Benefit Options
Benefit Services Division

INSURED INFORMATION

REQUIRED

Insured Information	Name- Last		First		MI	
	Employee EIN	Employee SSN	Sex ☐M ☐F	Date of Birth	Agency	
Address	Street		City	State	Zip	
Contact Information	Home Phone	Cell Phone	Email	County		

REQUIRED

Select all that apply:

☐ New Enrollment ☐ Adding Dependent(s) ☐ Dropping Dependent(s)

☐ Address Change ☐ Terminate Coverage ☐ Mind Change (Please Write MIND CHANGE At Top Of Form)

SPOUSE/DEPENDENT INFORMATION

For Changes Only	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP	MEDICAL (M) DENTAL (D) VISION (V)
☐ Add ☐Drop				☐M ☐F		☐M ☐D ☐V
☐ Add ☐Drop				☐M ☐F		☐M ☐D ☐V
☐ Add ☐Drop				☐M ☐F		☐M ☐D ☐V
☐ Add ☐Drop				☐M ☐F		☐M ☐D ☐V
☐ Add ☐Drop				☐M ☐F		☐M ☐D ☐V

FOR RELATIONSHIP- YOU MUST MARK **SPOUSE**, **CHILD**, **STEPCHILD**, **PLACED** FOR ADOPTION, OR **GUARDIAN**.

Medical Plans - Employee Per Pay Period Cost Listed (26 Pay Periods)

Action	Plan Type	Provider	Coverage Level
□ Enroll □ Decline □ No Change	□ EPO	□ Cigna □ United HealthCare □ BCBS AZ □ Aetna	☐ Employee Only ($18.46) ☐ Employee + Spouse ($54.92) ☐ Employee + Child ($46.62) ☐ Employee & Family ($102.00)
□ Enroll □ Decline □ No Change	□ PPO	□ United HealthCare □ BCBS AZ □ Aetna	☐ Employee Only ($47.08) ☐ Employee + Spouse ($99.23) ☐ Employee + Child ($66.46) ☐ Employee & Family ($115.85)
□ Enroll □ Decline □ No Change	□ HSA	□ Aetna	☐ Employee Only ($9.23) ☐ Employee + Spouse ($27.69) ☐ Employee + Child ($23.54) ☐ Employee & Family ($51.23)

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.

Vision Plan - Employee Per Pay Period Cost Listed (26 Pay Periods)

Action	Provider	Coverage Level
□ Enroll □ Decline □ No Change	□ Avesis Vision Coverage	□ Employee Only ($1.84) □ Employee + Spouse ($5.97) □ Employee + Child ($5.89) □ Employee & Family ($7.43)

Dental Plans - Employee Per Pay Period Cost Listed (26 Pay Periods)

Action	Provider	Coverage Level
□ Enroll □ Decline □ No Change	□ Total Dental Administrators	□ Employee Only ($1.86) □ Employee + Spouse ($3.72) □ Employee + Child ($3.50) □ Employee & Family ($6.12)
□ Enroll □ Decline □ No Change	□ Delta Dental PPO Plus Premier	□ Employee Only ($14.30) □ Employee + Spouse ($30.33) □ Employee + Child ($23.34) □ Employee & Family ($48.26)

Short Term Disability - Employee Per Pay Period Cost Listed (26 Pay Periods)

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 - Employee Per Pay Period Cost Listed (26 Pay Periods)

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 Suplemental 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 - Employee Per Pay Period Cost Listed (26 Pay Periods)

☐ **I DECLINE DEPENDENT LIFE INSURANCE**

☐ **$2,000 ($0.43)** ☐ **$4,000 ($0.87)** ☐ **$6,000 ($1.30)** ☐ **$10,000 ($2.17)** ☐ **$12,000 ($2.60)**
☐ **$15,000 ($3.25)** ☐ **$50,000 ($10.85)**

*To qualify for $50,000 you must elect a minimum of $35,000 in Supplemental Life Insurance.

Beneficiary Information

Beneficiary Last Name, First Name	Beneficiary Date of Birth	Beneficiary SSN	Beneficiary Contact Number

Beneficiary Street, City, State, Zip Code

SIGNATURE REQUIRED

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

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