SUBMITTING A CHANGE REQUEST

Requested benefit changes must be submitted in writing to ADOA Benefit Services Division within **31 calendar days** of the event.

EFFECTIVE DATE OF THE CHANGE

The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event.

The effective date for benefit changes based on all other QLEs is the first day of the pay period, following the date the employee submits the requested change, in writing, to ADOA Benefit Services Division.

Please consult with ADOA Benefit Services Division to determine whether or not the life event you are experiencing qualifies under the regulations.

ELIGIBLE DEPENDENTS

A. Your legal spouse

B. Your child defined as:

- a. Your natural, adopted and/or stepchild who is under 26 years old;
- b. A person under the age of 26 for whom you have court-ordered guardianship;
- c. Your foster children under the age of 26;
- d. A child placed in your home by court order pending adoption;
- e. Your natural, adopted and/or stepchild;
  - i. Who was disabled as defined by 42 U.S.C. 1382c before the age of 26;
  - ii. Who continues to be disabled as defined by 42 U.S.C. 1382c;
  - iii. Who is dependent for support and maintenance upon you;
  - iv. For whom you had custody before the child was 26.

DEPENDENT DOCUMENTATION REQUIREMENTS

If your dependent child is approaching age 26 and has a disability, application for continuation of dependent status must be made within 31 days of the child's 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, that occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.

If you are enrolling a dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation such as a marriage license for a spouse or a birth certificate or court order for a dependent, is provided to the Benefit Services Division.

CHANGING YOUR BENEFITS

You may change your benefit elections during the year only when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next annual open enrollment period to make changes. Qualifying Life Events include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse;
- Changes in dependent status: birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, and student status;
- Changes in employment status or work schedule that affect benefit eligibility for you, your spouse, and/or dependent
- Changes in residence that result in different available plan options

Note: A Qualified Life Event (QLE) application must be submitted with all supporting documentation within 31 days of the QLE.

SUPPORTING DOCUMENTATION

ADOA requires proof of the qualifying life event. Examples of the documentation needed would be:

Marriage: marriage certificate

Divorce: divorce decree

Birth: birth certificate, crib card, or hospital verification letter

Legal Separation: legal separation documents

Adoption/Placement for Adoption: legal adoption papers

Death of Spouse or Dependent: Death Certificate

Loss or Gain of Coverage: letter from employer or health, dental, vision plans with date coverage ended/started

For more information, please vist our website **http://benefitoptions.az.gov/**

Questions? Please contact your agency's human resources liasion or contact ADOA - Benefit Services at **602-542-5008** or by e-mail at **benefitsissues@azdoa.gov**.

Arizona Department of Administration
Benefit Options
Benefit Services Division

2016 Benefit Options Enrollment Form - Active Employee

Arizona Department of Administration
Benefit Options
Benefit Services Division

Date Received:_____ Effective Date: _____

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
- ☐ Qualifying Life Event
- ☐ Adding Dependent(s)
- ☐ Dropping Dependent(s)
- ☐ Address Change
- ☐ Terminate Coverage
- ☐ Mind Change (Please Write MIND CHANGE At Top Of Form As Well)

Qualifying Life Event **Date of Event:____/_____/_____**

- ☐ Marriage
- ☐ Gain/Loss of Other Coverage
- ☐ Birth/Adoption
- ☐ Death of spouse/dependent
- ☐ Divorce/Legal Separation
- ☐ Moved out of plan's service area
- ☐ Change in Dependent Eligibility Status

***FOR QUALIFIED LIFE EVENTS: THIS FORM MUST BE SUBMITTED, ALONG WITH REQUIRED DOCUMENTATION WITHIN 31 DAYS OF THE QUALIFIED LIFE EVENT.**

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.

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 (ACA).

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.

Arizona Department of Administration
Benefit Options
Benefit Services Division