

2016 Benefit Options Enrollment Form - COBRA



APPLICANT 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
Employee Information	Employee Last Name, First Name		Email Address	Employee EIN or SSN	

REQUIRED	Select all that apply:	Qualifying Life Event	Date of Event: ___/___/___	
	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Qualifying Life Event	<input type="checkbox"/> Marriage	<input type="checkbox"/> Gain/Loss of Other Coverage
	<input type="checkbox"/> Adding Dependent(s)	<input type="checkbox"/> Dropping Dependents	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Death of spouse/dependent
	<input type="checkbox"/> Address Change	<input type="checkbox"/> Terminate Coverage	<input type="checkbox"/> Divorce/Legal Separation	

Vision Plan - Monthly Premiums Amount

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"/> Applicant Only (\$4.07) <input type="checkbox"/> Applicant + Spouse (\$13.20) <input type="checkbox"/> Applicant + Child (\$13.02) <input type="checkbox"/> Family (\$16.43)

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"/> Applicant Only (\$9.17) <input type="checkbox"/> Applicant + Spouse (\$18.34) <input type="checkbox"/> Applicant + Child (\$17.86) <input type="checkbox"/> Family (\$27.51)
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> Delta Dental PPO Plus Premier	<input type="checkbox"/> Applicant Only (\$36.66) <input type="checkbox"/> Applicant + Spouse (\$77.14) <input type="checkbox"/> Applicant + Child (\$61.69) <input type="checkbox"/> Family (\$120.63)

Medical Plan - Monthly Premiums Amount

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"/> BCBS AZ <input type="checkbox"/> Aetna	<input type="checkbox"/> Applicant Only (\$601.80) <input type="checkbox"/> Applicant + Spouse (\$1,273.98) <input type="checkbox"/> Applicant + Child (\$851.70) <input type="checkbox"/> Family (\$1,488.18)
<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"/> BCBS AZ <input type="checkbox"/> Aetna	<input type="checkbox"/> Applicant Only (\$674.22) <input type="checkbox"/> Applicant + Spouse (\$1,424.94) <input type="checkbox"/> Applicant + Child (\$953.70) <input type="checkbox"/> Family (\$1,662.60)
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline <input type="checkbox"/> No Change	<input type="checkbox"/> HSA	<input type="checkbox"/> Aetna	<input type="checkbox"/> Applicant Only (\$399.84) <input type="checkbox"/> Applicant + Spouse (\$847.62) <input type="checkbox"/> Applicant + Child (\$566.10) <input type="checkbox"/> Family (\$989.40)

*For the NAU Blue Cross Blue Shield Plan, rates visit: <http://hr.nau.edu/m/content/view/102/112>

ADOA USE ONLY

COBRA EFFECTIVE: _____	LENGTH OF COBRA: _____
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SPOUSE/DEPENDENT INFORMATION (FOR RELATIONSHIP- YOU MUST MARK SPOUSE, CHILD, STEPCHILD, PLACED FOR ADOPTION, OR GUARDIAN.)

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

Effective January 1, 2009, Social Security numbers (SSN) will be required for you and your 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.

FIRST PAYMENT FOR CONTINUATION COVERAGE

If you elect continuation coverage, you do not need to send payment with the Enrollment Form. **Your first payment is due (i.e., must be postmarked) no later than 45 days after the date your Enrollment Form was postmarked (or faxed, or scanned) and sent to ADOA – Benefit Services.** Keep in mind that your Enrollment Form will not be processed, and your COBRA coverage will not become effective, until payment is made in full. Further, if you fail to make your first payment within the 45 days allotted, you will lose all continuation coverage rights under the Plan.

If payment is made on time (as indicated above), COBRA continuation coverage will begin the day after your job-based coverage ended.

You are responsible for making sure that the amount of your first payment is correct. You may contact ADOA – Benefit Services at (602) 542-5008 or (800) 304-3687 to confirm the correct amount of your first payment.

MONTHLY PAYMENTS FOR CONTINUED COVERAGE

After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments thereafter. The amount due per month for each qualified beneficiary will be sent to you in a billing statement from ADOA – HITF. If you make a full payment on or before the due date, your continuation coverage under the Plan will continue for another month without a break. Billing statements are mailed as a courtesy. If you do not receive a bill, you may call ADOA – Benefit Services for assistance.

WHERE AND HOW TO SEND PAYMENTS

All payments for COBRA continuation coverage shall be made by check or money order and made out to: Arizona Department of Administration – HITF.

Send your payments to:
 Arizona Department of Administration – Health Insurance Trust Fund (HITF)
 100 N. 15th Ave., #202
 Phoenix, AZ 85007

EXTENSION OF COBRA COVERAGE

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled, or if a second qualifying life event occurs. You must notify the ADOA – Benefit Services Office of a disability or a second qualifying life event immediately in order to extend the period of continuation coverage. Failure to provide notice to the ADOA – Benefit Services Office of a disability or second qualifying event may affect your right to extend the period of continuation coverage. Please contact Benefit Services for additional information if you have experienced a qualifying life event.

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).

Signature: _____ Date: _____

**Return form & first payment to: ADOA, Health Insurance Trust Fund, 100 N. 15th Ave., Suite 202
 Phoenix, AZ 85007 or fax: 602-542-4744 or email to: benefitsissues@azdoa.gov.**

