INSTRUCTIONS FOR SUBMITTING A NEW RETIREMENT APPLICATION

To enroll in ADOA - Benefit Options retiree benefits,
fill out the blue "2018 Benefit Options Enrollment Form-Retiree/LTD" form on the other side of this page.
If you are Medicare eligible AND enrolling in **non-NAU** medical coverage, the blue "Medicare GenerationRx (Employer PDP) Form" enclosed with this form is also required along with a copy of your Medicare card or your Medicare entitlement letter.

ELIGIBLE RETIREES

The following persons are eligible to participate in the Arizona Benefit Options program:

A. Retirees receiving a pension under a State-sponsored retirement plan and continuing enrollment in the retiree health and/or dental plan.
B. Long-Term Disability (LTD) participants collecting benefits under a State-sponsored plan.
C. Eligible former elected officials and their eligible dependents if the elected official has at least five years of credited service in the Elected Officials Retirement Plan (EORP); was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.
D. Surviving spouses and qualified dependents covered at the time of the retiree's death.
E. Surviving spouses of former elected officials covered at the time of the official's death.
F. Surviving spouse and eligible dependents of a deceased law enforcement officer killed in the line of duty whether they were covered or uncovered at the time of death.
G. Surviving spouses and eligible dependents of an active member that is eligible to retire provided they were covered at the time of the employee's death.

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 Qualified Life Events (QLEs) is the first day of the next calendar month, following the date the retiree submits the requested change, in writing, to ADOA Benefit Services Division. Please consult with the ADOA Benefit Services Division to determine whether the life event you are experiencing qualifies under the regulations.

ELIGIBLE DEPENDENTS

Eligible dependents include:

1. Your legal spouse as defined by Arizona Statute
2. Your child(ren) under 26 years old defined as:
    a. Your natural child, adopted child, stepchild, foster child, or a child for whom you have court-ordered guardianship.
    b. Your child who is disabled and continues to be disabled as defined by 42 U.S.C. 1382c before the age of 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 must 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.

For dependents who are being enrolled for the first time, AND fall into the following categories: 1) stepchild, 2) court-ordered guardianship, 3) placed in your home by court order pending adoption, 4) different last name – you will need to submit a copy of the birth certificate or marriage license within 14 days to the ADOA Benefit Services Division to complete processing of benefits coverage. Failure to submit documentation will result in a loss of enrollment.

RETURN TO WORK RETIREES

Former retired State employees returning to active State employment can receive health benefits through the Benefit Options Health Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in active benefits and decline retiree benefits. Leaving State service is considered a Qualified Life Event (QLE). The QLE then allows them to enroll in retiree benefits again.

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BENEFITS

BILLING, PAYMENT, AND ELIGIBILITY INFORMATION - TERMS & CONDITIONS FORM*

Please read and initial each section, then sign at the bottom.

>FIRST BILL HAS 2-3 MONTHS OF PREMIUMS: If you are having your medical and/or dental premiums (monthly cost) deducted from your pension, it can take up to 2-3 months for this to appear on your pension. *You may receive a billing statement at the end of those 2-3 months for the premiums that are due.* It is strongly suggested that if you are a new retiree, that you set aside your first 2-3 months of premiums so that you can pay the balance in full when the billing statement arrives. ADOA is not legally authorized to make any sort of financial payment arrangements and any outstanding balance that is not paid will be referred to the next level of collections required to collect your outstanding debt.

☐ (Initials)

>PRORATED BILLING: I understand that prorated (partial) months of service for medical and/or dental will be billed directly by ADOA. If I am eligible for a subsidy from my retirement system, that it will not apply to prorated months.

☐ (Initials)

>VISION IS NOT STAND ALONE COVERAGE: I understand that if I elect vision coverage, that I must have medical and/or dental coverage as well and that vision is not available as a stand alone coverage. I understand that Avesis Vision will bill me separately and that if I am eligible for a subsidy through my retirement system that it will not apply towards my vision coverage.

☐ (Initials)

>BILLS ARE DUE IN FULL WITHIN 30 DAYS OF STATEMENT: I understand that I may receive a billing statement for my medical and/or dental premiums (monthly cost) and that the balance is due in full within 30 days from the date on that statement. I agree to pay any and all owed balances in full each month within 30 days of the date on the billed invoice. I understand that if payment is not received in full by the due date that the account may be forwarded to the next level of collections required to collect my outstanding debt.

☐ (Initials)

>UNPAID BILLS MEAN MY COVERAGE WILL BE TERMINATED: I understand that if I fail to pay my premiums (monthly costs) that my medical, dental, and/or vision coverage will be retroactively terminated and I become legally responsible for any services/claims received.

☐ (Initials)

>ELEGIBLITY FOR INSURANCE: I understand that if I have forfeited (refunded or cashed out) my pension or DO NOT collect a pension, I am not eligible for benefits with ADOA and my medical, dental, and/or vision coverage may be retroactively terminated and I will become legally responsible for any services/claims received.

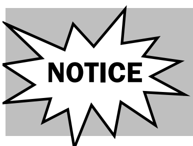
☐ (Initials)

I HAVE READ AND UNDERSTAND THIS AGREEMENT. I ACCEPT AND AGREE TO ALL OF ITS TERMS AND CONDITIONS. I ENTER INTO THIS AGREEMENT VOLUNTARILY, WITH FULL KNOWLEDGE OF ITS EFFECT.

Member Signature ______________________________ **Date** ____/____/____

Electronic Signatures Not Accepted

Member Name *(Please Print Clearly)* ______________________________



***This form is required along with the enrollment form for processing.**

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2018 BENEFIT OPTIONS RETIREE/LTD ENROLLMENT FORM* Effective Date: ____/____/____

NOTICE IF you DECLINE both medical and/or dental coverages, you will FORFEIT the ability to re-enroll with ADOA in the future.
IF you KEEP medical and/or dental coverage through ADOA, you may elect medical or dental coverage during future Open Enrollments.

REQUIRED

Insured Party

Retiree Name or Surviving Spouse - Last Name		First Name		MI
Employee ID Number (EIN) or SSN	Sex ☐M ☐F	Date of Birth	☐ Married ☐ Single	Medicare? ☐Yes ☐No
Street	City	State	ZIP	
Home Phone	Cell Phone	Email	County	

Retirement Information

Agency / University Retired From	Last Day Worked	Retirement Date	Retirement System ☐ASRS (ZA) ☐PSPRS/CORP/EORP (ZP) ☐OPTIONAL (ZT)

Survivor Information

Name of Deceased Employee or Retiree	Date of Death

Enrollment Type

Choose all that apply: ☐ New Retiree ☐ Retiree ☐ Surviving Spouse ☐ New LTD Participant ☐ LTD Participant ☐ Open Enrollment
☐ Qualifying Life Event (select event below) Event Date ____/____/____

☐ Marriage ☐ Birth/Adoption ☐ Gain/Loss of Other Coverage ☐ Other: ______________
☐ Address Change ☐ Divorce/Legal Separation ☐ Change in Dependent Eligibility Status ______________
☐ Terminate Coverage ☐ Death of Spouse/Dependent ☐ Moved Out of Plan's Service Area ______________

SPOUSE/DEPENDENT INFORMATION

CHOOSE ONE	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP Spouse=S Child=C Guardian=G Placed For Adoption=P Stepchild=T	MEDICARE A=Part A B=Part B C=Parts A & B D=Unknown E=None	COVERAGE 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

DENTAL PLAN - Monthly Premium Amount **

Cigna Dental HMO: ☐ Enroll ☐ Decline
☐ Retiree Only ($8.52) ☐ Retiree + One ($17.04) ☐ Retiree + One Child ($16.59) ☐ Retiree & Family ($25.54)

Delta Dental PPO Plus Premier: ☐ Enroll ☐ Decline
☐ Retiree Only ($35.94) ☐ Retiree + One ($75.63) ☐ Retiree + One Child ($60.48) ☐ Retiree & Family ($118.26)

VISION PLAN - Monthly Premium Amount *(Only Available if Medical and/or Dental Coverage is Selected)* **

Avesis Vision: ☐ Enroll ☐ Decline
☐ Retiree Only ($3.99) ☐ Retiree + One ($12.94) ☐ Retiree + One Child ($12.76) ☐ Retiree & Family ($16.10)

NOTICE **If you do not select ENROLL or DECLINE for EACH coverage: Medical, Dental, and Vision, THE COVERAGE WILL BE DECLINED AUTOMATICALLY.**
* The TERMS & CONDITIONS FORM must be submitted with this enrollment form for processing.

MEDICAL PLAN - MONTHLY PREMIUM AMOUNT WITHOUT MEDICARE**

EPO PLAN (select one): ☐ Aetna ☐ BCBSAZ ☐ Cigna ☐ UnitedHealthcare

☐ Enroll ☐ Decline

☐ Retiree Only ($652.30) ☐ Retiree + One ($1,525.70) ☐ Retiree & Family ($2,055.90)

PPO PLAN (select one): ☐ Aetna ☐ BCBSAZ ☐ UnitedHealthcare

☐ Enroll ☐ Decline

☐ Retiree Only ($907.50) ☐ Retiree + One ($2,209.90) ☐ Retiree & Family ($2,416.70)

PPO PLAN - NAU ONLY: ☐ BCBSAZ

☐ Enroll ☐ Decline

☐ Retiree Only ($820.04) ☐ Retiree + One ($1,640.07) ☐ Retiree & Family ($2,296.13)

Members with Medicare electing medical - You are required to complete the 2018 Group Part D Prescription Drug Enrollment Form

☐ I Have Medicare Part A	☐ I Have Medicare Part B

☐ ACCEPT MEDICAL AND PHARMACY COVERAGE - Medicare becomes primary for medical coverage and includes Medicare Part D prescription drug coverage. I understand that if I lose my prescription drug coverage, I will also lose my medical coverage.

☐ DECLINE MEDICAL AND PHARMACY COVERAGE

MEDICAL PLAN - MONTHLY PREMIUM AMOUNT WITH MEDICARE**

EPO PLAN (select one): ☐ Aetna ☐ BCBSAZ ☐ Cigna ☐ UnitedHealthcare

☐ Enroll ☐ Decline

☐ Retiree Only ($486.20) ☐ Retiree + One: Both with Medicare ($965.80)

☐ Retiree + One: One with Medicare, the other without ($1,126.40) ☐ Retiree & Family with Medicare ($1,282.60)

PPO PLAN (select one): ☐ Aetna ☐ BCBSAZ ☐ UnitedHealthcare

☐ Enroll ☐ Decline

☐ Retiree Only ($867.90) ☐ Retiree + One: Both with Medicare ($1,733.60)

☐ Retiree + One: One with Medicare, the other without ($1,914.00) ☐ Retiree & Family with Medicare ($2,178.00)

PPO PLAN - NAU ONLY: ☐ BCBSAZ (Medicare Generation Rx Form NOT required)

☐ Enroll ☐ Decline

☐ Retiree Only ($667.60) ☐ Retiree + One: Both with Medicare ($1,335.53)

☐ Retiree + One: One with Medicare, the other without ($1,487.65) ☐ Retiree & Family with Medicare ($1,835.34)

PLEASE READ AND INITIAL (IF electing Medical with ADOA and are Medicare eligible)

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. ____ (Initials)

2) If you enroll in the State of Arizona's medical plan and are enrolled in another Medicare prescription drug plan or individual Medicare Advantage plan–with or without prescription drug coverage–you will be disenrolled from that other 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. ____ (Initials)

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. ____ (Initials)

4) If you are enrolling in the ADOA Benefit Options Medical plan with Medicare (non-NAU), you are required to include a completed Medicare Generation RX form along with this enrollment form. ____ (Initials)

5) IF you DECLINE both medical and dental coverage, you will FORFEIT your right to re-enroll with ADOA in the future. ____ (Initials)

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:** ____/____/____

Member Name (Print Clearly): ______________________

Dependent/Spouse Signature: ______________________ **Date:** ____/____/____

(Any spouse/dependent with Medicare coverage with ADOA medical MUST sign; electronic signatures are not accepted)

Send to: ADOA, Benefit Services Div, 100 N. 15th Ave, Ste 260, Phoenix, AZ 85007
OR Fax: 602-542-4744 OR Email: benefitsissues@azdoa.gov