ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

ENROLLMENT ACTIVE EMPLOYEE 2024

Section 1: Member Information

LAST NAME			FIRST NAME		M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED	❑ NEW HIRE ❑ RE-HIRE ❑ RETURN-TO-WORK RETIREE ❑ QUALIFED LIFE EVENT (QLE)
STREET	CITY	ST	ZIP	COUNTY	
HOME PHONE	CELL PHONE	EMAIL			

Section 1a: Qualified Life Events (QLE)

❑ **I am currently enrolled and I have a QLE. Date of the event** _____

- List the names of dependents on page 2.
- Submit this form and all required documentation within 31 days of the Qualified Life Event (QLE). You can find additional accepted documents on benefitoptions.az.gov/QLE_docs. Failure to submit required documents will delay the processing of the change. You can submit by email at benefits@azdoa.gov or by fax to 602-542-4744.
- Note: birth, adoption, marriage, divorce, and legal separation can be submitted online. Please visit benefitoptions.az.gov/qle for full instructions on how submit quickly and easily online via hrsystems.az.gov > YES Portal.
- Effective Date: for changes based on QLEs are generally the pay period start date following your agency's receipt of your completed forms.
- Payroll Deductions: You are responsible for any payroll deductions from the effective date of the change.

❑ **I am enrolling in benefits for the first time.** Include your supporting documentation for all dependents listed on page 2. You do not need to fill out the event section listed below. You can submit by email at benefits@azdoa.gov or by fax to 602-542-4744. New hires/rehires you have 31 days to enroll.

Event	Supporting Documentation	Event	Status and Supporting Documentation	
❑ Birth	❑ Birth cert/crib card/hospital letter attached	❑ Guardianship/Foster/Custody	❑ Started ❑ Ended	❑ Court order attached
❑ Adoption	❑ Adoption order attached	❑ Court-Ordered Coverage of Dependents	❑ Started ❑ Ended	❑ Court order attached
❑ Marriage	❑ Marriage license attached	❑ Gain/Loss of Other Coverage via Spouse	❑ Gained ❑ Lost	❑ Proof attached
❑ Legal Separation	❑ Decree attached	❑ Change in Spouse or Dependent's Coverage	❑ Gained ❑ Lost	❑ Proof attached
❑ Divorce	❑ Decree attached	❑ Leave without Pay (LWOP) (Military/Other)	❑ Started ❑ Finished	❑ Evidence attached
❑ Death Spouse or Dependent	❑ Death certificate attached	❑ Medicare/Medicaid	❑ Enrolled ❑ Cancelled	❑ Evidence attached
		❑ Change in US Residence Impacting Coverage (Dental Only)		❑ Proof of new address attached
		❑ Change in Country of Residence		❑ Proof of new address attached
❑ Other, explain:		❑ Qualified for Public Marketplace Health Plan		❑ Proof of enrollment attached
		❑ Loss of Children's Health Insurance Program (CHIP) or Medicaid Coverage ***is a HIPAA Special Enrollment. Elect or decline any and/or all coverage.***		❑ Proof of disenrollment attached

Section 2: Dependent Information

❑ **If adding dependents <u>not previously covered</u>:** Submit this form AND the required supporting documentation, as listed on page 1. For more than three dependents, visit benefitoptions.az.gov/forms to find the "Additional Dependents Supplemental Form."

Social Security Numbers: By federal law, you are required to provide a Social Security Number (SSN) for <u>all</u> dependents enrolled in our plans. SSNs are needed to prepare IRS Form 1095-C under the Affordable Care Act (ACA). If you do not provide accurate SSNs, you may have a penalty.

1	**LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)**				❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	**BIRTH DATE**	❑ FEMALE ❑ MALE	**DISABLED?** ❑ YES ❑ NO	
	RELATIONSHIP (CHECK ONE) ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ GUARDIAN ❑ PLACED FOR ADOPTION		**SELECT PLAN(S)** ❑ MEDICAL ❑ DENTAL ❑ VISION		
2	**LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)**				❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	**BIRTH DATE**	❑ FEMALE ❑ MALE	**DISABLED?** ❑ YES ❑ NO	
	RELATIONSHIP (CHECK ONE) ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ GUARDIAN ❑ PLACED FOR ADOPTION		**SELECT PLAN(S)** ❑ MEDICAL ❑ DENTAL ❑ VISION		
3	**LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)**				❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	**BIRTH DATE**	❑ FEMALE ❑ MALE	**DISABLED?** ❑ YES ❑ NO	
	RELATIONSHIP (CHECK ONE) ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ GUARDIAN ❑ PLACED FOR ADOPTION		**SELECT PLAN(S)** ❑ MEDICAL ❑ DENTAL ❑ VISION		

Section 3: Health Plan – Premiums Per Pay Period

MED PLAN	CARRIER	Triple Choice Plan (TCP)	High Deductible Health Plan w/Health Savings Acct (HDHP+HSA)	
❑ ENROLL ❑ DECLINE	❑ BCBSAZ ❑ UHC	❑ $26.17 - EMPLOYEE ONLY ❑ $71.49 - EMPLOYEE + SPOUSE ❑ $57.30 - EMPLOYEE + 1 CHILD ❑ $121.61 - FAMILY	❑ $10.15 - EMPLOYEE ONLY ❑ $30.46 - EMPLOYEE + SPOUSE ❑ $25.89 - EMPLOYEE + 1 CHILD ❑ $56.35 - FAMILY	For your HSA contribution amount, see Section 6.

Section 4: Dental Plans – Premiums Per Pay Period

DENTAL PLAN	PPO – DELTA DENTAL	DHMO – UHC SOLSTICE S800B DENTAL***	
❑ ENROLL ❑ DECLINE	❑ $14.30 - EMPLOYEE ❑ $30.33 - EMPLOYEE + SPOUSE ❑ $23.34 - EMPLOYEE + 1 CHILD ❑ $48.26 - EMPLOYEE + FAMILY	❑ $1.64 - EMPLOYEE ❑ $3.29 - EMPLOYEE + SPOUSE ❑ $3.08 - EMPLOYEE + 1 CHILD ❑ $5.46 - EMPLOYEE + FAMILY	***Residents of these states/territories cannot enroll in the DHMO: AK, AL, AR, DE, HI, IA, ID, LA, ME, MS, MT, ND, NE, NH, OK, RI, SD, VT, WV, WY, GU, USVI, and PR. Check provider availability on smilestateofaz.com, plan S800B.

Section 5: Vision Plans – Premiums Per Pay Period

VISION PLAN	PROVIDER - AVESIS ADVANTAGE PROGRAM	
❑ ENROLL ❑ DECLINE	❑ $1.72- EMPLOYEE ❑ $5.70 - EMPLOYEE + SPOUSE	❑ $5.65 - EMPLOYEE + 1 CHILD ❑ $7.11 – EMPLOYEE + FAMILY

Section 6: Health Savings Accounts & Flexible Spending Accounts

To sign up for the following accounts, Please obtain the applicable form on benefitoptions.az.gov/forms and submit it with this application.

- Health Savings Account (HSA) to use with a High Deductible Health Plan (HDHP)
- Flexible Spending Accounts (FSA) (healthcare, limited purpose, or daycare/eldercare)
- Limited Purpose Flexible Spending Account – for dental and vision only, used with the HDHP

Section 7: Basic Life Insurance Beneficiary

The State of Arizona provides $15,000 in Basic Life insurance to benefits eligible employees at no cost.
Please choose a beneficiary for your Basic Life policy.

❑ Use the beneficiary listed here for my Supplemental Life Policy under Section 8.

BASIC LIFE BENEFICIARY LAST NAME, FIRST NAME, MI	
BENEFICIARY DATE OF BIRTH	BENEFICIARY SOCIAL SECURITY NUMBER
BENEFICIARY STREET ADDRESS	
BENEFICIARY CITY, STATE, ZIP	
BENEFICIARY PHONE NUMBER	

Section 8: Supplemental Life and AD&D Insurance - Premiums Per Pay Period

Supplemental Life and AD&D insurance is available in increments of $5,000, up to a $20,000 increase per year, up to 3x your annual salary, not to exceed $500,000. Premiums for the first $35,000 of supplemental life insurance are pretax. Premium is based on your age as of Jan. 1 (the 1st day of the Plan Year). To calculate rates, see p. 17 of the *Active Employee Enrollment Guide* on benefitoptions.az.gov/newhire.

❑ ELECT - TOTAL AMT **$**_____
❑ DECLINE

SUPPLEMENTAL LIFE BENEFICIARY LAST NAME, FIRST NAME, MI	
BENEFICIARY DATE OF BIRTH	BENEFICIARY SOCIAL SECURITY NUMBER
BENEFICIARY STREET ADDRESS	
BENEFICIARY CITY, STATE, ZIP	
BENEFICIARY PHONE NUMBER	

Section 9: Dependent Life & AD&D Ins – Premiums/Pay Period

This is coverage is one policy for your eligible spouse and all dependents. Elect or decline coverage as indicated below.
To learn more, see the *Active Enrollment Guide* on benefitoptions.az.gov/newhire.

COVERAGE & COST/PAY PERIOD

❑ $2,000 - $0.43
❑ $4,000 - $0.87
❑ $6,000 - $1.30

COVERAGE & COST/PAY PERIOD

❑ $10,000 - $2.17
❑ $12,000 - $2.60
❑ $15,000 - $3.25
❑ $50,000† - $10.85

❑ DECLINE COVERAGE

† To have a $50,000 dependent policy, you must elect at least $35,000 in Supplemental Life for yourself.

Section 10: Short Term Disability Ins – Premiums/Pay Period

Monthly premiums are $0.316 for every $100 of your annual base pay, up to the first $70,000, if applicable. You pay premiums each bi-weekly pay period.

Calculate Per Pay Period Premium:

- Step 1: (Annual Salary ÷ 100) x $0.316 = Annual Premium
- Step 2: Annual Premium ÷ 26 Pay Periods = Pay Period Premium

Example:

- Step 1: ($45,000 ÷ 100) = 450 x $0.316 = $142.20
- Step 2: $142.20 ÷ 26 = $5.47 Pay Period Premium

To learn more, the *Active Enrollment Guide* on benefitoptions.az.gov.

❑ ELECT ❑ DECLINE

Section 11: Acknowledgement and Authorization

I certify under penalty of perjury that the information provided in this application for employee benefits, including Social Security Numbers, addresses, spouse and/or dependent child(ren) information is true and accurate. I understand that providing false information may subject me to a denial of employee benefits, disciplinary action and prosecution pursuant to A.R.S. §13-2310, 13-2311, 13-2407, 13-2702 and other laws. I acknowledge I have received the Summary of Benefits and Coverage Documents as part of the Affordable Care Act (ACA) electronically via benefitoptions.az.gov. I authorize the release of this information to my employer, ADOA and insurance carriers.

❑ I authorize my employer to reduce my salary by pre-tax or after-tax deductions (in accordance with IRC Section 125), either prospectively or retroactively, for my elected benefits. Any pre-tax contributions are ineligible as itemized deductions for income tax purposes.
❑ I understand that I can only change my benefits during open enrollment or by written notification to ADOA-Benefits within 31 days of a qualified life event.
❑ I understand that while on any unpaid status, I am responsible for paying my benefit premiums. Upon return to paid status, I may have pre-tax or after-tax payroll deductions. If I fail to pay premiums as required, my benefits may be cancelled and I will be responsible for any paid claims.

EFFECTIVE DATE: All elections are effective January 1 – December 31, 2024.

MEMBER NAME (PRINT CLEARLY) _____ DATE _____

MEMBER SIGNATURE _____

RETURN TO: ARIZONA DEPARTMENT OF ADMINISTRATION - BENEFITS, 1802 W. JACKSON ST. #94, PHOENIX, AZ 85007
PH: 602-542-5008 | TOLL-FREE: 1-800-304-3687 | BENEFITOPTIONS.AZ.GOV | FAX: 602-542-4744 | BENEFITS@AZDOA.GOV