ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2019 BENEFIT OPTIONS RETIREE/LTD ENROLLMENT

ARIZONA DEPARTMENT OF ADMINISTRATION (ADOA)-BENEFIT SERVICES DIVISION

ADOA USE: EFFECTIVE DATE: _____/_____/2019

Section A: Member Information

LAST NAME			FIRST NAME		M.I.
EMPLOYEE ID NUMBER (EIN)	**SOCIAL SECURITY NUMBER (REQUIRED)**	**BIRTH DATE**	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED	❑ MEDICARE ENROLLED
STREET	**CITY**	**ST**	**ZIP**	**COUNTY**	❑ RETURN-TO-WORK RETIREE
HOME PHONE	**CELL PHONE**		**EMAIL**		

Section B: Retirement Information

AGENCY/UNIVERSITY RETIRED FROM	LAST DAY WORKED	RETIREMENT DATE	RETIREMENT SYSTEM
			❑ ASRS (ZA) ❑ PSPRS/CORP/EORP (ZP) ❑ OPTIONAL (ZT)

Section C: Survivor Information

NAME OF DECEASED EMPLOYEE OR RETIREE	DATE OF DEATH

Section D: Enrollment Type

MEMBER TYPE:

❑ NEW RETIREE ❑ NEW LTD PARTICIPANT
❑ CURRENT RETIREE ❑ CURRENT LTD PARTICIPANT
❑ SURVIVING SPOUSE

QUALIFIYING LIFE EVENT:

❑ MARRIAGE
❑ DIVORCE/LEGAL SEPARATION
❑ DEATH: SPOUSE OR DEPENDENT
❑ TERMINATE COVERAGE
❑ GAIN/LOSS OF OTHER COVERAGE
❑ DEPENDENT ELEGIBITY STATUS CHANGE
❑ BIRTH/ADOPTION
❑ ADDRESS CHANGE
❑ MOVED OUT OF PLAN SERVICE AREA

Section E: Dependent Information

IF ADDING DEPENDENTS NOT PREVIOUSLY COVERED: SUBMIT THIS FORM AND REQUIRED SUPPORTING DOCUMENTS, AS LISTED ON BENEFITOPTIONS.AZ.GOV UNDER THE EMPLOYEE TAB, TO BENEFITSISSUES@AZDOA.GOV. FOR ADDITIONAL DEPENDENTS, CONTINUE TO LIST INFORMATION ON A SEPARATE PIECE OF PAPER. **SOCIAL SECURITY NUMBERS (SSN):** FEDERAL LAW REQUIRES SSNS FOR ALL ENROLLED DEPENDENTS IN ORDER TO PREPARE IRS FORM 1095-C UNDER THE AFFORDABLE CARE ACT (ACA). **ENROLLMENTS WILL NOT BE PROCESSED WITHOUT SSNS.**

1	**LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)**			❑ FEMALE ❑ MALE	**CHECK ONE:** ❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	**BIRTH DATE**	**DISABLED?** ❑ YES ❑ NO	**MEDICARE** ❑ Part A ❑ Part B ❑ Parts A&B ❑ Unknown ❑ None	
	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)**			❑ FEMALE ❑ MALE	**CHECK ONE:** ❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	**BIRTH DATE**	**DISABLED?** ❑ YES ❑ NO	**MEDICARE** ❑ Part A ❑ Part B ❑ Parts A&B ❑ Unknown ❑ None	
	RELATIONSHIP (CHECK ONE) ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ GUARDIAN ❑ PLACED FOR ADOPTION			**SELECT PLAN(S)** ❑ MEDICAL ❑ DENTAL ❑ VISION	

Section F: Dental Plans – Monthly Premiums

➲ **NOTICE:** Be sure to select ENROLL or DECLINE for EACH coverage: Medical, Dental, Vision. *Any coverage not selected will be declined automatically*.

DENTAL PLANS (CHECK ONE)	PROVIDER (CHECK ONE)	
	PPO – DELTA DENTAL	**DHMO – CIGNA DENTAL****
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ $35.94 - RETIREE ❑ $75.63 - RETIREE + SPOUSE ❑ $60.48- RETIREE + 1 CHILD ❑ $118.26 - RETIREE + FAMILY	❑ $8.52 - RETIREE ❑ $17.04 - RETIREE + SPOUSE ❑ $16.59 - RETIREE + 1 CHILD ❑ $25.54 - RETIREE + FAMILY

** Coverage not available in AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.

Section G: Vision Plans – Monthly Premiums

➲ **NOTICE:** Be sure to select ENROLL or DECLINE for EACH coverage: Medical, Dental, Vision. *Any coverage not selected will be declined automatically.*

VISION PLANS (CHECK ONE)	COVERAGE LEVEL (CHECK ONE)	PROVIDER: AVESIS ADVANTAGE PROGRAM
❑ ENROLL ❑ DECLINE*** ❑ CHANGE ❑ NO CHANGE	❑ $3.99 - RETIREE ❑ $12.94 - RETIREE + SPOUSE ❑ $12.76 - RETIREE + 1 CHILD ❑ $16.10 - RETIREE + FAMILY	• ***If you decline Avesis Advantage coverage, you will automatically be enrolled in the Avesis Discount Program at no charge. • You **MUST** purchase Medical or Dental coverage to purchase Vision coverage. Vision **cannot** be purchased as stand-alone coverage. • Avesis will send bills directly to you for payment. Failure to pay your bill by the due date will result in loss of coverage.

Section H-1: Health Plan Without Medicare – Monthly Premiums

➲ **NOTICE:** Be sure to select ENROLL or DECLINE for EACH coverage: Medical, Dental, Vision. *Any coverage not selected will be declined automatically.*

MEDICAL PLAN (CHECK ONE)	CARRIER	PLAN		
		EPO	PPO	NAU ONLY – BCBSAZ PPO
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ AETNA ❑ BCBSAZ ❑ CIGNA*** ❑ UHC	❑ $671.87 - RETIREE ONLY ❑ $1,571.47 - RETIREE + ONE ❑ $2,117.58 - RETIREE + FAMILY	❑ $934.73 - RETIREE ONLY ❑ $2,276.20 - RETIREE + ONE ❑ $2,489.20 - RETIREE + FAMILY ****Cigna not available for PPO.*	❑ $820.04 - RETIREE ONLY ❑ $1,640.07 - RETIREE + ONE ❑ $2,296.13 - RETIREE + FAMILY

Section H-2: Heath Plan With Medicare – Monthly Premiums

MEDICAL PLAN (CHECK ONE)	CARRIER	PLAN		
		EPO	PPO	NAU ONLY – BCBSAZ PPO
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ AETNA ❑ BCBSAZ ❑ CIGNA*** ❑ UHC	❑ $500.79 - RETIREE ONLY ❑ $994.77 - RETIREE + ONE BOTH W/MEDICARE ❑ $1,160.19 - RETIREE + ONE ONE W/MEDICARE, ONE WITHOUT ❑ $1,321.08 - RETIREE + FAMILY	❑ $893.94 - RETIREE ONLY ❑ $1,785.61 - RETIREE + ONE BOTH W/MEDICARE ❑ $1,971.42 - RETIREE + ONE ONE W/MEDICARE, ONE WITHOUT ❑ $2,243.34 - RETIREE + FAMILY ****Cigna not available for PPO.*	❑ $667.60 - RETIREE ONLY ❑ $1,335.53 - RETIREE + ONE BOTH W/MEDICARE ❑ $1,487.65 - RETIREE + ONE ONE W/MEDICARE, ONE WITHOUT ❑ $1,835.34 - RETIREE + FAMILY

Section H-3: Medicare Pharmacy Coverage

Members with Medicare electing medical **MUST COMPLETE** the VibrantRx 2019 Group Part D Prescription Drug Enrollment Form. Download from benefitoptions.az.gov, Forms tab.
Include a copy of Medicare card or letter of entitlement.
❑ NAU Only: Form Not Required

I have:
❑ Medicare Part A
❑ Medicare Part B

❑ I 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.

Section H-4: ADOA Medicare Coverage Rules – Read and initial if electing Medical (Non-NAU)

INITIALS	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 any other Medicare Advantage or supplemental 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 Vibrant 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.

Section I-1: Billing and Payment Information - Terms And Conditions*

INITIALS	• If your medical and/or dental premiums (monthly cost) are deducted from your pension, it can take up to 2-3 months for this to appear on your pension. At the end of those 2-3 months, you may receive a billing statement 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	• I understand that prorated (partial) months of service for medical and/or dental will be billed directly by ADOA and that if I am eligible for a subsidy from my retirement system that it will not apply to prorated months.
INITIALS	• 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 standalone 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	• 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 the 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	• I understand that if I fail to pay my premiums (monthly costs) that my medical, dental, and/or vision coverage may be retroactively terminated and I would be legally responsible for any services/claims received.
INITIALS	• 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 would be legally responsible for any services/claims received.

Section I-2: Acknowledgement of Billing and Payment - Terms and Conditions:

I have read and understand this billing and payment agreement, and I accept and agree to all of its terms and conditions.
I enter into this agreement voluntarily, with full knowledge of its effects.

Member Signature: _____ **DATE:** _____

Member Name (PRINT)**:** _____

Section J: Acknowledgement of Application Information

- 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) electronically via benefitoptions.az.gov under the Resources tab.
- I hereby acknowledge that I must select to enroll or decline for each coverage: medical, dental and vision. Any coverage not selected will be declined automatically.
- **I hereby acknowledge 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.**

EFFECTIVE DATE: All elections are effective January 1, 2019 – December 31, 2019.

Member Signature: _____ **DATE:** _____

Member Name (PRINT)**:** _____

Dependent/Spouse Signature: _____ **DATE:** _____

(ANY SPOUSE/DEPENDENT WITH MEDICARE COVERAGE WITH ADOA MEDICAL MUST SIGN; ELECTRONIC SIGNATURES ARE NOT ACCEPTED)

RETURN TO:
ARIZONA DEPARTMENT OF ADMINISTRATION (ADOA), BENEFIT SERVICES DIVISION, 100 N. 15TH AVE, STE 260, PHOENIX, AZ 85007
FAX: 602-542-4744 | EMAIL: BENEFITSISSUES@AZDOA.GOV | PHONE: 602-542-5008 | TOLL-FREE: 1-800-304-3687