ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2019 BENEFIT OPTIONS ENROLLMENT-EMPLOYEE

Section A: Member Information

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

Section B: Enrollment Type

B-1: ENROLLMENT TYPE (choose all that apply)	B-2: QUALIFIYING LIFE EVENT (QLE)*
❑ NEW ENROLLMENT ❑ QUALIFIYING LIFE EVENT (QLE)*	❑ MARRIAGE ❑ BIRTH**/ADOPTION ❑ DIVORCE/LEGAL SEPARATION ❑ GAIN/LOSS OF OTHER COVERAGE ❑ DEPENDENT ELIGIBITY STATUS CHANGE ❑ DEATH: SPOUSE OR DEPENDENT ❑ MOVED OUT OF PLAN SERVICE AREA

***31-DAY DEADLINE**: Submit this form, a Declaration for Change Form & required supporting documents, within 31 days of the QLE. Forms on benefitoptions.az.gov under the Employee tab.

****NEWBORNS**: Are covered under your insurance for the first 31 days only. The child must be enrolled as a dependent by the 31st day after birth. Miss the deadline and you will have to wait until the next Open Enrollment or QLE. To add the child, follow the QLE instructions listed at right under 31-Day Deadline.

Section C: 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 more than three 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). Failure to provide SSNs may result in a tax penalty.

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

Section D: Health Plans – Premiums Per Pay Period (26 Pay Periods)

MEDICAL PLAN (CHECK ONE)	CARRIER	PLAN		
		EPO	PPO	HDHP with HSA† (Aetna only)
❑ ENROLL	❑ AETNA	❑ $20.92 - EMPLOYEE ONLY	❑ $53.34 - EMPLOYEE ONLY	❑ $10.15 - EMPLOYEE ONLY
❑ DECLINE	❑ BCBSAZ	❑ $62.23 - EMPLOYEE + SPOUSE	❑ $112.43 - EMPLOYEE + SPOUSE	❑ $30.46 - EMPLOYEE + SPOUSE
❑ CHANGE	❑ CIGNA***	❑ $52.82 - EMPLOYEE + 1 CHILD	❑ $75.30 - EMPLOYEE + 1 CHILD	❑ $25.89 - EMPLOYEE + 1 CHILD
❑ NO CHANGE	❑ UHC	❑ $115.57 - FAMILY	❑ $131.25 - FAMILY	❑ $56.35 - FAMILY
			****Cigna not available for PPO.*	*† For HSA contribution information, see Section F.*

Section E: Health Savings Accounts & Flexible Spending Accounts

- For a Health Savings Account (HSA) to use with a High Deductible Health Plan (HDHP)
- OR a Flexible Spending Accounts (FSA) (healthcare, dependent care, limited purpose)
- Obtain the applicable form on benefitoptions.az.gov under the Forms tab. Fill out the form and submit it with this enrollment application.

Section F: Dental Plans – Premiums Per Pay Period (26 Pay Periods)

DENTAL PLANS (CHECK ONE)	PROVIDER (CHECK ONE)		
	PPO – DELTA DENTAL	DHMO – CIGNA DENTAL††	
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ $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	††Coverage not available in AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.

Section G: Vision Plans – Premiums Per Pay Period (26 Pay Periods)

VISION PLANS (CHECK ONE)	COVERAGE LEVEL (CHECK ONE)	PROVIDER: AVESIS ADVANTAGE PROGRAM
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ $1.84 - EMPLOYEE ❑ $5.97 - EMPLOYEE + SPOUSE ❑ $5.89 - EMPLOYEE + 1 CHILD ❑ $7.43 - EMPLOYEE + FAMILY	If you decline Avesis Advantage coverage, you will automatically be enrolled in the Avesis Discount Program at no charge.

Section H: 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.

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

Section I: Supplemental Life and AD&D Insurance – Premiums Per Pay Period (26 Pay Periods)

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 January 1 (the first day of the Plan Year). To calculate rates, see pg. 14 of the *Active Employee 2019 Benefit Options Enrollment Guide* found on benefitoptions.az.gov under the Employees tab. ❑ ELECT - TOTAL AMOUNT OF EMPLOYEE COVERAGE: $____________ ❑ DECLINE

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

Section J: Dependent Life & AD&D Insurance – Premiums Per Pay Period (26 Pay Periods)

For more information - benefitoptions.az.gov under the Employees tab.

COVERAGE LEVEL	COST/PAY PERIOD	COVERAGE LEVEL	COST/PAY PERIOD
$2,000	$0.43	$10,000	$2.17
$4,000	$0.87	$12,000	$2.60
$6,000	$1.30	$15,000	$3.25
		$50,000*	$10.85

**To elect $50,000 for a dependent, you must elect $35,000 in Supplemental Life for yourself.*

❑ ELECT - DEPENDENT COVERAGE LEVEL: $__________ ❑ DECLINE

Section K: Short Term Disability Insurance – Premiums Per Pay Period (26 Pay Periods)

Coverage is $0.18 per pay period for every $100 of monthly earned income.

Example: $2,500/mo salary ÷ $100 = 25
25 x $0.18 = $4.50 per paycheck

Online calculator: bit.ly/HartfordCalc

For more information, see pg. 14 of the *Active Employee 2019 Benefit Options Enrollment Guide* found on benefitoptions.az.gov under the Employees tab.

❑ ELECT ❑ DECLINE

Section L: Acknowledgements 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 applicable provisions of the law.
- 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 under the Resources tab.
- I authorize the release of this information to my employer, the Arizona Department of Administration (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-Benefit Services Division within 31 calendar days of a qualified life event.
- I understand that while on any unpaid status, I am responsible for paying my benefits 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, 2019 – December 31, 2019.

MEMBER NAME (PRINT CLEARLY) ______________________________ **DATE** ____________________

MEMBER SIGNATURE ______________________________

(ELECTRONIC SIGNATURES NOT ACCEPTED)

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