ARIZONA
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES

2021 BENEFIT OPTIONS ENROLLMENT-EMPLOYEE

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
MAILING ADDRESS	CITY	ST	ZIP	COUNTY	❑ RETURN-TO-WORK RETIREE
HOME PHONE	CELL PHONE		EMAIL		

Section 2: Enrollment Type

2-A: ENROLLMENT TYPE (choose all that apply)	2-B: QUALIFYING LIFE EVENT (QLE)*		
❑ NEW ENROLLMENT ❑ QUALIFYING LIFE EVENT (QLE)*	❑ MARRIAGE ❑ BIRTH**/ADOPTION ❑ DIVORCE/LEGAL SEPARATION	❑ GAIN/LOSS OF OTHER COVERAGE ❑ DEPENDENT ELIGIBILITY 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 3: 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):** ADOA 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 4: Health Plans – Premiums Per Pay Period

MEDICAL PLAN (CHECK ONE)	CARRIER	PLAN		
		Triple Choice Plan (TCP)	High Deductible Health Plan w/Health Savings Account (HDHP+HSA)	
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ 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 HSA contribution information, see Section **5.**

Section 5: 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 forms on benefitoptions.az.gov/forms. Fill out the form and submit it with this enrollment application.

Section 6: Dental Plans – Premiums Per Pay Period

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 7: Vision Plans – Premiums Per Pay Period

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	

Section 8: 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	M.I.	BENEFICIARY MAILING ADDRESS, CITY, STATE, ZIP
BENEFICIARY DATE OF BIRTH	**BENEFICIARY SOCIAL SECURITY NUMBER**		**BENEFICIARY PHONE NUMBER**

Section 9: Supplemental Life and AD&D Insurance – Premiums Per Pay Period

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 first day of the Plan Year). To calculate rates, visit www.bit.ly/BeneScout or see p. 16 of the *Active Employee 2021 Benefit Enrollment Guide* on benefitoptions.az.gov/forms. ❑ **ELECT - TOTAL AMOUNT OF EMPLOYEE COVERAGE: $_____** ❑ **DECLINE**

SUPPLEMENTAL LIFE BENEFICIARY LAST NAME	FIRST NAME	M.I.	BENEFICIARY MAILING ADDRESS, CITY, STATE, ZIP
BENEFICIARY DATE OF BIRTH	**BENEFICIARY SOCIAL SECURITY NUMBER**		**BENEFICIARY PHONE NUMBER**

Section 10: Dependent Life & AD&D Ins - Premiums Per Pay Period

To learn more, see p. 15 of the *Active Employee 2021 Enrollment Guide* on benefitoptions.az.gov/forms.

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 11: Short Term Disability Ins - Premiums Per 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. To learn more, see p. 17 of the *Active Employee 2021 Enrollment Guide* on benefitoptions.az.gov/forms.

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

❑ ELECT ❑ DECLINE

Section 12: 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, 2021 – December 31, 2021.

MEMBER NAME (PRINT CLEARLY) _____ **DATE** _____

MEMBER SIGNATURE: _____ ***(ELECTRONIC SIGNATURES NOT ACCEPTED)***

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