ARIZONA
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES

2022 BENEFIT OPTIONS OPEN ENROLLMENT ACTIVE 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
STREET		CITY	ZIP	COUNTY	☐ RETURN-TO-WORK RETIREE
HOME PHONE	CELL PHONE		EMAIL		

Section 2: Dependent Information

If adding dependents <u>not previously covered</u>: Submit this form AND the required supporting documentation, as listed on benefitoptions.az.gov/QLE to benefits@azdoa.gov. For more than three dependents, continue to list information on a separate piece of paper.

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 an IRS penalty.

1	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)				CHECK ONE: ☐ 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)				CHECK ONE: ☐ 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)				CHECK ONE: ☐ 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

MEDICAL PLAN	CARRIER	Triple Choice Plan (TCP)	High Deductible Health Plan w/Health Savings Account (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 – CIGNA 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	***Coverage not available in AK, ID, ME, MT, NH, NM, ND, PR, SD, VT, USVI, WV and WY.

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 a Health Savings Account (HSA) to use with a High Deductible Health Plan (HDHP), OR a Flexible Spending Accounts (FSA) (healthcare, limited purpose, or daycare/eldercare), please obtain the applicable form on benefitoptions.az.gov under the Forms tab. Fill out the form and submit it with this application.

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 BASIC LIFE 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 2022 Enrollment Guide* on benefitoptions.az.gov/newhire.

❑ ELECT - TOTAL AMOUNT OF EMPLOYEE COVERAGE: **$**_____
❑ 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 Per Pay Period

To learn more, see the p. 17 of the *Active Employee 2022 Enrollment Guide* on benefitoptions.az.gov/newhire.

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

❑ ELECT - TOTAL AMOUNT OF DEPENDENT COVERAGE: **$**_____
❑ DECLINE

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

Section 10: 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.

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, see the p. 16 of the *Active Employee 2022 Enrollment Guide* on benefitoptions.az.gov/newhire.

❑ 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 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. I authorize the release of this information to my employer, the Arizona Department of Administration (ADOA) and insurance carriers. Further:

❑ 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-HR-Benefits 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 – December 31, 2022.

MEMBER NAME (PRINT CLEARLY) _____ DATE _____

MEMBER SIGNATURE _____

RETURN TO: ARIZONA DEPARTMENT OF ADMINISTRATION-HR- BENEFITS, PO BOX 6548, PHOENIX, AZ 85005
FAX: 602-542-4744 | BENEFITS@AZDOA.GOV | PH: 602-542-5008 | TOLL-FREE: 1-800-304-3687 | BENEFITOPTIONS.AZ.GOV