

Section 1: Member Information

LAST NAME			FIRST NAME			M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> NEW HIRE <input type="checkbox"/> RE-HIRE <input type="checkbox"/> RETURN-TO-WORK RETIREE <input type="checkbox"/> QUALIFIED LIFE EVENT (QLE)	
STREET		CITY	ST	ZIP	COUNTY	
HOME PHONE	CELL PHONE	EMAIL				

Section 1a: New Hires/Rehires/Return-to-Work Retirees

I am enrolling in benefits as a new hire/rehire/return-to-work retiree. My start date is _____. You have 31 days to enroll.

- For your dependents, please refer to section 1b for the supporting documentation. **However, you do not need to fill out Section 1b.**
- Submit this form and your documents by email to benefits@azdoa.gov or fax to 602-542-4744.

Section 1b: Qualified Life Events (QLE)

I have a QLE. Date of the event _____. Choose type of event from the chart below.

- Submit this form and all required documentation as shown below 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.
- Note: birth, adoption, marriage, divorce, and legal separation can be submitted online. Please visit benefitoptions.az.gov/qle for full instructions on how to 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.
- Submit this form and your documents by email to benefits@azdoa.gov or fax to 602-542-4744.

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

Section 2: Dependent Information

If adding dependents not previously covered: 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 all 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)				<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	RELATIONSHIP (CHECK ONE) <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> GUARDIAN <input type="checkbox"/> PLACED FOR ADOPTION		SELECT PLAN(S) <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION		
2	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)				<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	RELATIONSHIP (CHECK ONE) <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> GUARDIAN <input type="checkbox"/> PLACED FOR ADOPTION		SELECT PLAN(S) <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION		
3	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)				<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	RELATIONSHIP (CHECK ONE) <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> GUARDIAN <input type="checkbox"/> PLACED FOR ADOPTION		SELECT PLAN(S) <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> 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)
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE	<input type="checkbox"/> BCBS <input type="checkbox"/> UHC	<input type="checkbox"/> \$26.17 - EMPLOYEE ONLY <input type="checkbox"/> \$71.49 - EMPLOYEE + SPOUSE <input type="checkbox"/> \$57.30 - EMPLOYEE + 1 CHILD <input type="checkbox"/> \$121.61 - FAMILY	<input type="checkbox"/> \$10.15 - EMPLOYEE ONLY <input type="checkbox"/> \$30.46 - EMPLOYEE + SPOUSE <input type="checkbox"/> \$25.89 - EMPLOYEE + 1 CHILD <input type="checkbox"/> \$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 ***
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE	<input type="checkbox"/> \$14.30 - EMPLOYEE <input type="checkbox"/> \$30.33 - EMPLOYEE + SPOUSE <input type="checkbox"/> \$23.34 - EMPLOYEE + 1 CHILD <input type="checkbox"/> \$48.26 - EMPLOYEE + FAMILY	<input type="checkbox"/> \$1.64 - EMPLOYEE <input type="checkbox"/> \$3.29 - EMPLOYEE + SPOUSE <input type="checkbox"/> \$3.08 - EMPLOYEE + 1 CHILD <input type="checkbox"/> \$5.46 - EMPLOYEE + FAMILY <small>***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.</small>

Section 5: Vision Plans – Premiums Per Pay Period

VISION PLAN	PROVIDER - AVESIS ADVANTAGE PROGRAM
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE	<input type="checkbox"/> \$1.72- EMPLOYEE <input type="checkbox"/> \$5.70 - EMPLOYEE + SPOUSE <input type="checkbox"/> \$5.65 - EMPLOYEE + 1 CHILD <input type="checkbox"/> \$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 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-HR-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, 2023.

MEMBER NAME (PRINT CLEARLY) _____ DATE _____

MEMBER SIGNATURE _____

**RETURN TO: ARIZONA DEPARTMENT OF ADMINISTRATION-HR- 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**