ARIZONA
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES

2021 BENEFIT OPTIONS RETIREE/LTD ENROLLMENT

ARIZONA DEPARTMENT OF ADMINISTRATION (ADOA)-BENEFIT SERVICES DIVISION

ADOA USE: EFFECTIVE DATE: _____/_____/____

Section 1: Member Information

INITIAL X_______ **I ACKNOWLEDGE THAT MY ENROLLMENT FORM WILL NOT BE PROCESSED WITHOUT ALL REQUIRED SUPPORTING DOCUMENTATION.** (See Section 5.)

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

Section 2: Retirement Information

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

Section 3: Survivor Information

NAME OF DECEASED EMPLOYEE OR RETIREE - LAST NAME, FIRST NAME, M.I.	DATE OF DEATH

Section 4: Enrollment Type

MEMBER TYPE:
- ❑ NEW RETIREE
- ❑ NEW LTD PARTICIPANT
- ❑ CURRENT RETIREE
- ❑ CURRENT LTD PARTICIPANT
- ❑ SURVIVING SPOUSE

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

Section 5: Dependent Information

TO ADD DEPENDENTS NOT PREVIOUSLY COVERED: SUBMIT THIS FORM AND REQUIRED SUPPORTING DOCUMENTS, AS LISTED ON BENEFITOPTIONS.AZ.GOV UNDER THE RETIREE TAB, QUALIFIED LIFE EVENT, TO BENEFITSISSUES@AZDOA.GOV. FOR MORE THAN 2 DEPENDENTS, ATTACH AN ADDITIONAL SHEET. **FORMS WITHOUT REQUIRED SUPPORTING DOCUMENTS WILL NOT BE PROCESSED.**
SOCIAL SECURITY NUMBERS (SSN): ADOA REQUIRES SSNS FOR ALL ENROLLED DEPENDENTS IN ORDER TO ISSUE IRS FORM 1095-C. FAILURE TO PROVIDE SSNS MAY RESULT IN A TAX PENALTY.

#					CHECK ONE:
1	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)			❑ FEMALE ❑ MALE	❑ 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	❑ 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 6: 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	❑ $35.94 - RETIREE	❑ $8.52 - RETIREE
❑ DECLINE	❑ $75.63 - RETIREE + SPOUSE	❑ $17.04 - RETIREE + SPOUSE
❑ CHANGE	❑ $60.48- RETIREE + 1 CHILD	❑ $16.59 - RETIREE + 1 CHILD
❑ NO CHANGE	❑ $118.26 - RETIREE + FAMILY	❑ $25.54 - RETIREE + FAMILY

***The Cigna DHMO is not available in the following states and territories: AK, ID, ME, MT, NH, NM, ND, PR, SD, VT, USVI, WV and WY.*

Section 7: Vision Plans – Quarterly 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	COVERAGE - QUARTERLY PREMIUMS	PROVIDER: AVESIS ADVANTAGE PROGRAM
❑ ENROLL ❑ DECLINE* ❑ CHANGE ❑ NO CHANGE	❑ $11.16 - RETIREE/QUARTER** ❑ $37.08 - RETIREE + SPOUSE/QUARTER** ❑ $36.72 - RETIREE + 1 CHILD/QUARTER** ❑ $46.20 - RETIREE + FAMILY/QUARTER**	• *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 bills you directly for payment QUARTERLY: JAN 1, APR 1, JUL 1, SEP 1.** • Failure to pay your vision insurance bill by the due date will result in loss of coverage.

Section 8-A: 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: TRIPLE CHOICE PLAN (TCP) MONTHLY	NAU ONLY – BCBSAZ PPO MONTHLY
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ BCBSAZ ❑ UHC	❑ $708.53 - RETIREE ❑ $1,657.21 - RETIREE + ONE ❑ $2,233.12 - RETIREE + FAMILY	❑ $837.36 - RETIREE ❑ $1,674.71 - RETIREE + ONE ❑ $2,344.64 - RETIREE + FAMILY

Section 8-B: Heath Plan With Medicare – Monthly Premiums

MEDICAL PLAN (CHECK ONE)	CARRIER	PLAN: TRIPLE CHOICE PLAN (TCP) MONTHLY	NAU ONLY – BCBSAZ PPO MONTHLY
❑ ENROLL ❑ DECLINE ❑ CHANGE ❑ NO CHANGE	❑ BCBSAZ ❑ UHC	❑ $528.11 - RETIREE ❑ $1,049.05 - RETIREE + ONE - Both w/Medicare ❑ $1,223.49 - RETIREE + ONE - One w/Medicare, One without ❑ $1,393.16 - RETIREE + FAMILY	❑ $681.70 - RETIREE ❑ $1,363.55 - RETIREE + ONE - Both w/Medicare ❑ $1,519.07 - RETIREE + ONE- One w/Medicare, One without ❑ $1,874.11 - RETIREE + FAMILY

Section 8-C: Medicare Pharmacy Coverage

Members with Medicare electing medical **MUST COMPLETE** the VibrantRx 2020 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 8-D: ADOA Medicare Coverage Rules – Read and initial if electing Medical (Non-NAU)

INITIAL X_______	**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.
INITIAL X_______	**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.
INITIAL X_______	**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.
INITIAL X_______	**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.
INITIAL X_______	**5)** IF you DECLINE both medical and dental coverage, you will FORFEIT your right to re-enroll with ADOA in the future.

Section 9-A: Billing and Payment - Terms and Conditions

➲ **NOTICE:** By initialing each section, I agree to the following:

INITIAL X_______	1) **First Billing in 2-3 Months -** 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 several months of premiums. *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.
INITIAL X_______	2) **Paying Online -** The first statement you receive will be mailed to you with instructions for paying premiums online or by mail.
INITIAL X_______	3) **Prorated Months -** Prorated (partial) months of service for medical and/or dental will be billed directly by ADOA. If I am eligible for a subsidy from my retirement system, it will not apply to prorated months.
INITIAL X_______	4) **Vision -** If I elect Vision coverage, I must have medical and/or dental coverage also. Vision is not available as a standalone coverage. Avesis Vision will bill me separately on Jan 1, Apr 1, Jun 1 and Sep 1. If I am eligible for a subsidy from my retirement system, it does not apply towards my vision coverage.
INITIAL X_______	**5) Payment in Full - I AGREE TO PAY ANY AND ALL OWED BALANCES IN FULL EACH MONTH BY THE DUE DATE ON THE BILLING STATEMENT.**
INITIAL X_______	6) **Payment by Due Date -** If payment is not received in full by the due date on the billing statement, the account may be forwarded to a collection agency. Payment plans and/or partial payments are not permitted.
INITIAL X_______	7) **Failure to Pay -** If I fail to pay my premiums (monthly costs) that my medical, dental, and/or vision coverage may be retroactively terminated. I am legally responsible for any services/claims received.
INITIAL X_______	8) **Forfeit/Cash Out -** If I have forfeited (refunded or cashed out) my pension or DO NOT collect a pension, I am ineligible for ADOA benefits. My medical, dental, and/or vision coverage may be retroactively terminated. I am legally responsible for any services/claims received.

Section 9-B: 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 as stated in Section 9-A above.

Member Signature: ______________________________ **DATE:** ______________________

Member Name (PRINT)**:** ______________________________

Section 10: Acknowledgement of Application Information

1) I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true.
2) 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.
3) 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.
4) I hereby acknowledge that I must elect to enroll or decline for each coverage: medical, dental and vision. Any coverage not selected will be declined automatically.
5) **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, 2021 – December 31, 2021.

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.*

Section 11: Mailing Address and Contact Information

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