

**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	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> MEDICARE ENROLLED
MAILING ADDRESS		CITY	ST	ZIP	COUNTY <input type="checkbox"/> RETURN-TO-WORK RETIREE
HOME PHONE	CELL PHONE		EMAIL		

**Section 2: Retirement Information**

AGENCY/UNIVERSITY RETIRED FROM	LAST DAY WORKED	RETIREMENT DATE	RETIREMENT SYSTEM <input type="checkbox"/> ASRS (ZA) <input type="checkbox"/> PSPRS/CORP/EORP (ZP) <input type="checkbox"/> OPTIONAL (ZT)
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**Section 3: Survivor Information**

NAME OF DECEASED EMPLOYEE OR RETIREE - LAST NAME, FIRST NAME, M.I.	DATE OF DEATH
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**Section 4: Enrollment Type**

<b>MEMBER TYPE:</b> <input type="checkbox"/> NEW RETIREE <input type="checkbox"/> NEW LTD PARTICIPANT <input type="checkbox"/> CURRENT RETIREE <input type="checkbox"/> CURRENT LTD PARTICIPANT <input type="checkbox"/> SURVIVING SPOUSE	<b>QUALIFYING LIFE EVENT:</b> <input type="checkbox"/> MARRIAGE <input type="checkbox"/> DIVORCE/LEGAL SEPARATION <input type="checkbox"/> DEATH: SPOUSE DEPENDENT	<input type="checkbox"/> TERMINATE COVERAGE ON DATE _____ <input type="checkbox"/> GAIN/LOSS OF OTHER COVERAGE <input type="checkbox"/> DEPENDENT ELIGIBILITY STATUS CHANGE <input type="checkbox"/> BIRTH/ADOPTION	<input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> MOVED OUT OF PLAN SERVICE AREA
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**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 BENEFITISSUES@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.

1	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)				<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	CHECK ONE: <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A&B <input type="checkbox"/> Unknown <input type="checkbox"/> None		
	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"/> FEMALE <input type="checkbox"/> MALE	CHECK ONE: <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A&B <input type="checkbox"/> Unknown <input type="checkbox"/> None		
	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 6: Dental Plans – Monthly Premiums**

➡ **NOTICE:** Select ENROLL/DECLINE/CHANGE/NO CHANGE for EACH coverage. *Any coverage not selected will be declined automatically.*

DENTAL PLANS (CHECK ONE)	PROVIDER (CHECK ONE)		*Coverage not available in AK, ME, MT, NH, NM, ND, PR, SD, VT, USVI, and WY.
	PPO – DELTA DENTAL	DHMO – CIGNA DENTAL**	
<input type="checkbox"/> ENROLL	<input type="checkbox"/> \$35.94 - RETIREE	<input type="checkbox"/> \$8.52 - RETIREE	
<input type="checkbox"/> DECLINE	<input type="checkbox"/> \$75.63 - RETIREE + SPOUSE	<input type="checkbox"/> \$17.04 - RETIREE + SPOUSE	
<input type="checkbox"/> CHANGE	<input type="checkbox"/> \$60.48 - RETIREE + 1 CHILD	<input type="checkbox"/> \$16.59 - RETIREE + 1 CHILD	
<input type="checkbox"/> NO CHANGE	<input type="checkbox"/> \$118.26 - RETIREE + FAMILY	<input type="checkbox"/> \$25.54 - RETIREE + FAMILY	

RETIREE/LTD BENEFITS ENROLLMENT 2022 | ARIZONA DEPARTMENT OF ADMINISTRATION-ADOA

**Section 7: Vision Plans - Quarterly Premiums**

**NOTICE:** Select ENROLL/DECLINE/CHANGE/NO CHANGE for EACH coverage. *Any coverage not selected will be declined automatically.*

VISION PLANS	COVERAGE - QUARTERLY PREMIUMS	PROVIDER: AVESIS ADVANTAGE PROGRAM
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE* <input type="checkbox"/> CHANGE <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> \$11.16 - RETIREE/QUARTER* <input type="checkbox"/> \$37.08 - RETIREE + SPOUSE/QUARTER* <input type="checkbox"/> \$36.72 - RETIREE + 1 CHILD/QUARTER* <input type="checkbox"/> \$46.20 - RETIREE + FAMILY/QUARTER*	<ul style="list-style-type: none"> <li>You <b>MUST</b> purchase Medical or Dental coverage to purchase Vision coverage. Vision <b>cannot</b> be purchased as stand-alone coverage.</li> <li>*Avesis bills you directly for payment <b>QUARTERLY: JAN 20, MAR 18, JUN 20, SEP 20.</b></li> <li>Failure to pay your vision insurance bill by the due date will result in loss of coverage.</li> </ul>

**Section 8-A: Health Plan Without Medicare - Monthly Premiums**

**NOTICE:** Select ENROLL/DECLINE/CHANGE/NO CHANGE for EACH coverage. *Any coverage not selected will be declined automatically.*

MEDICAL PLAN (CHECK ONE)	CARRIER	PLAN	
		TRIPLE CHOICE PLAN (TCP) MONTHLY	NAU ONLY - BCBSAZ PPO MONTHLY
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE <input type="checkbox"/> CHANGE <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> BCBSAZ <input type="checkbox"/> UHC	<input type="checkbox"/> \$708.53 - RETIREE <input type="checkbox"/> \$1,657.21 - RETIREE + ONE <input type="checkbox"/> \$2,233.12 - RETIREE + FAMILY	<input type="checkbox"/> \$837.36 - RETIREE <input type="checkbox"/> \$1,674.71 - RETIREE + ONE <input type="checkbox"/> \$2,344.64 - RETIREE + FAMILY

**Section 8-B: Health Plan With Medicare - Monthly Premiums**

MEDICAL PLAN (CHECK ONE)	CARRIER	PLAN	
		TRIPLE CHOICE PLAN (TCP) MONTHLY	NAU ONLY - BCBSAZ PPO MONTHLY
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE <input type="checkbox"/> CHANGE <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> BCBSAZ <input type="checkbox"/> UHC	<input type="checkbox"/> \$528.11 - RETIREE <input type="checkbox"/> \$1,049.05 - RETIREE + ONE - BOTH w/MEDICARE <input type="checkbox"/> \$1,223.49 - RETIREE + ONE - ONE w/MEDICARE, ONE w/OUT <input type="checkbox"/> \$1,393.16 - RETIREE + FAMILY	<input type="checkbox"/> \$681.70 - RETIREE <input type="checkbox"/> \$1,363.55 - RETIREE + ONE - BOTH w/MEDICARE <input type="checkbox"/> \$1,519.07 - RETIREE + ONE - ONE w/MEDICARE, ONE w/OUT <input type="checkbox"/> \$1,874.11 - RETIREE + FAMILY

**Section 8-C: Medicare Pharmacy Coverage**

Members with Medicare electing medical **MUST COMPLETE** the VibrantRx 2022 Group Part D Prescription Drug Enrollment Form. Download from [benefitoptions.az.gov](http://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: Billing and Payment - Terms and Conditions**

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

INITIAL X _____	1) <b>First Billing in 2-3 Months</b> - 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. <i>It is strongly suggested that if you are a new retiree, that you set aside your first 2-3 months of premiums</i> 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) <b>Paying Online</b> - The first statement you receive will be mailed to you with instructions for paying premiums online or by mail.
INITIAL X _____	3) <b>Prorated Months</b> - 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) <b>Vision</b> - 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) <b>Payment in Full</b> - I AGREE TO PAY ANY AND ALL OWED BALANCES IN FULL EACH MONTH BY THE DUE DATE ON THE BILLING STATEMENT.
INITIAL X _____	6) <b>Payment by Due Date</b> - 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) <b>Failure to Pay</b> - 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) <b>Forfeit/Cash Out</b> - 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: Acknowledgement of Application Information and Billing & Payment Terms**

- 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](http://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, 2022 - December 31, 2022.

Member Signature: \_\_\_\_\_

DATE: \_\_\_\_\_

Member Name (PRINT): \_\_\_\_\_

Dependent/Spouse Signature\*: \_\_\_\_\_

DATE: \_\_\_\_\_

*\*ANY SPOUSE/DEPENDENT WITH MEDICARE COVERAGE WITH ADOA MEDICAL MUST SIGN.*

**Section 10: Mailing Address and Contact Information**

**RETURN FORM TO:** ARIZONA DEPT. OF ADMINISTRATION (ADOA), HR-BENEFITS, PO BOX 6548, PHOENIX, AZ 85007

**EMAIL:** [BENEFITS@AZDOA.GOV](mailto:benefits@azdoa.gov) | **PHONE:** 602-542-5008 | **TOLL-FREE:** 800-304-3687 | **FAX:** 602-542-4744 | **WEB:** [BENEFITOPTIONS.AZ.GOV](http://benefitoptions.az.gov)