

Section 1: Member Information

INITIAL	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
HOME PHONE			CELL PHONE		EMAIL	

Answering these questions is your choice. You can't be denied coverage for not filling them out.

ETHNICITY – Choose all that apply: Not of Hispanic, Latino/a, or Spanish origin Mexican, Mexican American, Chicano/a Puerto Rican
 Cuban Another Hispanic, Latino/a, or Spanish origin I choose not to answer

RACE – Choose all that apply: American Indian or Alaska Native Asian Indian Black or African American Chinese Filipino
 Guamanian or Chamorro Japanese Korean Native Hawaiian Other Asian Other Pacific Islander
 Samoan Vietnamese White I choose not to answer

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) <input type="checkbox"/> ASRS/PSPRS – Dual Retirement
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Section 3: Survivor Information

NAME OF DECEASED EMPLOYEE OR RETIREE – LAST NAME, FIRST NAME, M.I.	DATE OF DEATH	EMPLOYEE ID NUMBER (EIN)
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Section 4: Enrollment Type

MEMBER TYPE: <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	QUALIFYING LIFE EVENT: <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/retireeQLE, to benefits@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"/> STEPCCHILD <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"/> STEPCCHILD <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		

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

Section 6: Dental Plans – Monthly Premiums

DENTAL PLANS	PPO – DELTA DENTAL	DHMO – UHC DENTAL**	
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE <input type="checkbox"/> CHANGE <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> \$35.94 - RETIREE <input type="checkbox"/> \$75.63 - RETIREE + SPOUSE <input type="checkbox"/> \$60.48 - RETIREE + 1 CHILD <input type="checkbox"/> \$118.26 - RETIREE + FAMILY	<input type="checkbox"/> \$8.52 - RETIREE <input type="checkbox"/> \$17.04 - RETIREE + SPOUSE <input type="checkbox"/> \$16.59 - RETIREE + 1 CHILD <input type="checkbox"/> \$25.54 - RETIREE + FAMILY	<i>Coverage not available in these states: AK, AL, AR, DE, HI, IA, ID, LA, ME, MS, MT, ND, NE, NH, OK, RI, SD, VT, WV, WY</i> Note: Enrollment in the UHC Medical Plan is not required to enroll in the UHC Solstice Plan.

Section 7: Vision Plans – Annual Premiums

VISION PLANS	COVERAGE – ANNUAL 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"/> \$44.64/yr - RETIREE <input type="checkbox"/> \$148.32/yr - RETIREE + SPOUSE <input type="checkbox"/> \$146.88/yr - RETIREE + 1 CHILD <input type="checkbox"/> \$184.80/yr - RETIREE + FAMILY	<ul style="list-style-type: none"> You MUST purchase Medical or Dental coverage to purchase Vision coverage. *Avesis bills you directly for the ANNUAL premium – Midyear enrollment is pro-rated by month. Monthly payments are not permitted. Failure to pay the premium in full by the due date will result in coverage loss.

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

MEDICAL PLAN	CARRIER	TRIPLE CHOICE PLAN (TCP)	NAU ONLY – BCBSAZ PPO
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE <input type="checkbox"/> CHANGE <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> BCBS <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	CARRIER	TRIPLE CHOICE PLAN (TCP)	NAU ONLY – BCBSAZ PPO
<input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE <input type="checkbox"/> CHANGE <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> BCBS <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, 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	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	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 plan, you will be disenrolled from the state plan.
INITIAL	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	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	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	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. <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	2) Paying Online – The first statement you receive will be mailed to you with instructions for paying premiums online or by mail.
INITIAL	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	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 will bill me annually. If I receive a subsidy from my retirement system, it does not apply to vision coverage.
INITIAL	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	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	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	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: 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 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 – December 31, 2023.

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: ADOA HR–BENEFITS, 1802 W JACKSON ST #94, PHOENIX, AZ 85007

EMAIL: BENEFITS@AZDOA.GOV | **PHONE:** 602-542-5008 | **TOLL-FREE:** 800-304-3687 | **FAX:** 602-542-4744 | **WEB:** BENEFITOPTIONS.AZ.GOV