

# Benefit Options

Choice. Value. Health.

## STATE OF ARIZONA ACTIVE OPEN ENROLLMENT FORM 2009-2010

**2009 - 2010 OPEN ENROLLMENT FORM**

DATE RECEIVED

AGENCY

EFFECTIVE DATE

**NEW EMPLOYEE**    **QUALIFIED LIFE EVENT**    **ADDRESS CHANGE**    **TERMINATION**

### EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH
CITY, STATE, ZIP CODE	WORK PHONE NUMBER (   )	HOME PHONE NUMBER (   )

Are you enrolling a Domestic Partner? Yes   or   No

Is your Domestic Partner: (circle one) Pre-Tax   or   Post-Tax

Are you enrolling an Older Child(ren) that is neither a full-time student nor a disabled dependent? (circle one) Yes   or   No

Is your Older Child(ren): (circle one) Pre-Tax   or   Post-Tax

*If you have already enrolled a qualified domestic partner or older child, you do not need to submit additional paperwork. If you are wanting to add a domestic partner or older child during this open enrollment, please go to [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov) to obtain the instructions and needed documentation.*

### MEDICAL PLANS (Employee Monthly Cost Listed)

**I DECLINE MEDICAL COVERAGE**

#### EPO PLANS

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
CIGNA EPO		<input type="checkbox"/> \$39.00		<input type="checkbox"/> \$97.00		<input type="checkbox"/> \$79.00		<input type="checkbox"/> \$178.00
AMERIBEN EPO		<input type="checkbox"/> \$39.00		<input type="checkbox"/> \$97.00		<input type="checkbox"/> \$79.00		<input type="checkbox"/> \$178.00
AETNA EPO		<input type="checkbox"/> \$39.00		<input type="checkbox"/> \$97.00		<input type="checkbox"/> \$79.00		<input type="checkbox"/> \$178.00
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$39.00		<input type="checkbox"/> \$97.00		<input type="checkbox"/> \$79.00		<input type="checkbox"/> \$178.00

#### PPO PLANS

AMERIBEN PPO		<input type="checkbox"/> \$154.00		<input type="checkbox"/> \$328.00		<input type="checkbox"/> \$309.00		<input type="checkbox"/> \$443.00
AETNA PPO		<input type="checkbox"/> \$154.00		<input type="checkbox"/> \$328.00		<input type="checkbox"/> \$309.00		<input type="checkbox"/> \$443.00
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$154.00		<input type="checkbox"/> \$328.00		<input type="checkbox"/> \$309.00		<input type="checkbox"/> \$443.00

#### HSA OPTION

AETNA HSA		<input type="checkbox"/> \$25.00		<input type="checkbox"/> \$80.00		<input type="checkbox"/> \$59.00		<input type="checkbox"/> \$150.00
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### DENTAL PLANS (Employee Monthly Cost Listed)

**I DECLINE DENTAL COVERAGE**

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$5.00		<input type="checkbox"/> \$9.00		<input type="checkbox"/> \$14.00
DELTA DENTAL INDEMNITY/PPO		<input type="checkbox"/> \$29.86		<input type="checkbox"/> \$67.93		<input type="checkbox"/> \$118.12

### VISION PLAN (Employee Monthly Cost Listed)

**I DECLINE VISION COVERAGE**

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$4.83		<input type="checkbox"/> \$13.52		<input type="checkbox"/> \$16.86

Effective January 1, 2009, all Active State employees will be required to provide social security numbers (SSNs) for their enrolled dependents.

The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that the Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for coordination of benefit purposes.

**STATE OF ARIZONA ACTIVE  
OPEN ENROLLMENT FORM 2009-2010 CONTINUED**

**DEPENDENTS - List all eligible dependents to be enrolled or disenrolled in medical, dental, and/or vision plans**

LAST NAME, FIRST NAME, M.I. <small>(USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)</small>	Date of Birth (MM/DD/YY)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER	REQUIRED	REQUIRED			Y OR N	Y OR N	A OR D	
<b>Employee</b>			S- Spouse C- Child D- Domestic Partner G- Guardian P- Placed for adoption T- Stepchild					
<b>Spouse or Domestic Partner</b>			<input type="checkbox"/> S <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V

**SHORT-TERM DISABILITY**

The Hartford Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay \$0.70 for every \$100 of earned income per month. Please see the Open Enrollment Guide for more information regarding Short-Term Disability coverage.

I DECLINE SHORT-TERM DISABILITY       I ELECT SHORT-TERM DISABILITY

**SUPPLEMENTAL LIFE INSURANCE**

Supplemental coverage is available in increments of \$5,000. Your cost for Supplemental Life and AD&D insurance is based on your age as of October 1st (the first day of the plan year). Premiums for Supplemental Life coverage above \$35,000 are paid on an after-tax basis. You may elect to increase your Supplemental Life coverage during Open Enrollment. The maximum amount you may elect during this Open Enrollment is 3 times your base salary or \$300,000.00 whichever is lower.

I DECLINE SUPPLEMENTAL LIFE INSURANCE

Total amount of employee coverage: \$ \_\_\_\_\_

**DEPENDENT LIFE INSURANCE**

I DECLINE DEPENDENT LIFE INSURANCE

<input type="checkbox"/> \$2,000	\$0.94/MONTH	Plan Code 02	<input type="checkbox"/> \$12,000	\$5.64/MONTH	Plan Code 12
<input type="checkbox"/> \$4,000	\$1.88/MONTH	Plan Code 04	<input type="checkbox"/> \$15,000	\$7.05/MONTH	Plan Code 15
<input type="checkbox"/> \$6,000	\$2.82/MONTH	Plan Code 06	<input type="checkbox"/> \$50,000	\$24.25/MONTH	Plan Code 50

Beneficiary Last Name, First Name		Date of Birth
Beneficiary Street, City, State, Zip Code		Phone No.

**EMPLOYEE AUTHORIZATION AND SIGNATURE**

I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/domestic partner and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In addition, I have read and understand the declarations.

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

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 Or fax to: 602-542-4744