



# STATE OF ARIZONA ACTIVE 2012 ENROLLMENT FORM

## 2012 ENROLLMENT FORM

### ONLY COMPLETE THIS FORM IF MAKING CHANGES TO YOUR CURRENT COVERAGE

DATE RECEIVED	AGENCY	EFFECTIVE DATE
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OPEN ENROLLMENT  
  NEW EMPLOYEE  
  QUALIFIED LIFE EVENT  
  ADDRESS CHANGE  
  TERMINATION

#### EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN	EMPLOYEE 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 same-sex Domestic Partner? (circle one)**      Yes      or      No

To qualify a same-sex Domestic Partner for the first time, you will need to complete and submit the DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized). This form can be found on the Benefit Options website at [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov).

#### MEDICAL PLANS (Employee Per Pay Period Cost Listed)

I DECLINE MEDICAL COVERAGE    OR     I ELECT TO KEEP MY CURRENT MEDICAL COVERAGE    OR

##### EPO PLANS

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
CIGNA EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102
AMERIBEN/BCBS of AZ EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102
AETNA EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$18.46		<input type="checkbox"/> \$54.92		<input type="checkbox"/> \$46.62		<input type="checkbox"/> \$102

##### PPO PLANS

AMERIBEN/BCBS of AZ PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31
AETNA PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$71.54		<input type="checkbox"/> \$161.54		<input type="checkbox"/> \$152.77		<input type="checkbox"/> \$224.31

##### HSA OPTION

AETNA HSA		<input type="checkbox"/> \$12		<input type="checkbox"/> \$47.08		<input type="checkbox"/> \$37.38		<input type="checkbox"/> \$89.08
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#### DENTAL PLANS(Employee Per Pay Period Cost Listed)

I DECLINE DENTAL COVERAGE    OR     I ELECT TO KEEP MY CURRENT DENTAL COVERAGE    OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$2.31		<input type="checkbox"/> \$4.15		<input type="checkbox"/> \$6.46
DELTA DENTAL INDEMNITY/PPO		<input type="checkbox"/> \$14.30		<input type="checkbox"/> \$32.71		<input type="checkbox"/> \$56.82

#### VISION PLAN (Employee Per Pay Period Cost Listed)

I DECLINE VISION COVERAGE    OR     I ELECT TO KEEP MY CURRENT VISION COVERAGE    OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$2.23		<input type="checkbox"/> \$6.24		<input type="checkbox"/> \$7.78

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.



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**DEPENDENTS - List all eligible dependents to be enrolled 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	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
<b>Employee</b>			S- Spouse C- Child D- Same-Sex Domestic Partner G- Guardian P- Placed for adoption T- Stepchild			
<b>Spouse or Same-Sex 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 \$0.69 for every \$100 of earned income per month. Please visit [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov) 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 January 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.

I DECLINE SUPPLEMENTAL LIFE INSURANCE     
  I ELECT TO KEEP MY CURRENT SUPPLEMENTAL LIFE INSURANCE

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

**DEPENDENT LIFE INSURANCE**

I DECLINE DEPENDENT LIFE INSURANCE     
  I ELECT TO KEEP MY CURRENT 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
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Beneficiary Street, City, State, Zip Code

**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. I authorize my employer to reduce my salary by applicable pre-tax dollars or reduce my paycheck by the applicable after-tax dollars for the insurance programs which I have elected. 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

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