ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2018 Benefit Options Enrollment Form – COBRA

APPLICANT INFORMATION

REQUIRED INFORMATION

Applicant Last Name		Applicant First Name		Applicant MI	
Applicant State of AZ EIN (if applicable)	Applicant SSN	Applicant Sex ☐M ☐F	Applicant Date of Birth ___/___/____		
Applicant Street Address		Applicant City		Applicant ST	Applicant Zip / Applicant County
Applicant Home Phone	Applicant Cell Phone	Applicant Email			
State Applicant EIN	State Applicant SSN	State Applicant Email		State Applicant Cell Phone	State Applicant Agency

Select all that apply:
- ☐ New Enrollment
- ☐ Adding Dependent(s)
- ☐ Address Change
- ☐ Qualifying Life Event
- ☐ Dropping Dependent(s)
- ☐ Terminate Coverage

QUALIFIED LIFE EVENT*
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Change in Dependent Eligibility Status

Date of Event: ___/___/____
- ☐ Gain/Loss of Other Coverage
- ☐ Death of Spouse/Dependent
- ☐ Moved out of plan's service area

NOTICE

***FOR A QUALIFIED LIFE EVENT: THIS FORM MUST BE SUBMITTED ALONG WITH REQUIRED DOCUMENTATION WITHIN 31 DAYS OF THE QUALIFIED LIFE EVENT.**

SPOUSE/DEPENDENT INFORMATION

ACTION	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)[1]	DATE OF BIRTH	SEX	RELATIONSHIP[2]	MEDICAL (M) DENTAL (D) VISION (V)
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V

[2]FOR RELATIONSHIP- YOU MUST MARK **SPOUSE**, **CHILD**, **STEPCHILD**, **PLACED** FOR ADOPTION, OR **GUARDIAN**.

MEDICAL PLANS– PER MONTH PREMIUMS LISTED*

ACTION	PLAN TYPE	PROVIDER	COVERAGE LEVEL	
☐ Enroll ☐ Decline	☐ EPO	☐ Aetna ☐ Blue Cross Blue Shield of AZ ☐ Cigna ☐ UnitedHealthcare	☐ Applicant Only ☐ Applicant + Spouse ☐ Applicant + Child ☐ Applicant & Family	$676.69 $1431.64 $956.53 $1670.18
☐ Enroll ☐ Decline	☐ PPO	☐ Aetna ☐ Blue Cross Blue Shield of AZ ☐ UnitedHealthcare	☐ Applicant Only ☐ Applicant + Spouse ☐ Applicant + Child ☐ Applicant & Family	$756.62 $1,599.11 1,070.22 1,865.77
☐ Enroll ☐ Decline	☐ HDHP	☐ Aetna	☐ Applicant Only ☐ Applicant + Spouse ☐ Applicant + Child ☐ Applicant & Family	$449.82 $953.02 $636.24 $1,111.31

NOTICE

****If you do not select ENROLL or DECLINE for EACH coverage: Medical, Dental, and Vision, THE COVERAGE WILL BE DECLINED AUTOMATICALLY.**

**For the NAU Blue Cross Blue Shield Plan, rates visit: http://hr.nau.edu/m/content/view/102/112*

*[1]**Social Security Numbers:** All active Applicants are required to provide Social Security Numbers (SSNs) for their enrolled dependents. The SSN is used as the basis for the Medicare Health insurance claim number (HICN). The HICN identifies Medicare beneficiaries receiving health care services, and assists Medicare in its responsibilities to pay for health care and operate the program. 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 & Accountability Act Privacy Rule (HIPPA). Please note that the Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for benefit coordination.*

ADOA USE ONLY

COBRA EFFECTIVE: ____/____/____ **LENGTH OF COBRA: _____**

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VISION PLAN–PER MONTH PREMIUMS LISTED

ACTION	PROVIDER	COVERAGE LEVEL
□ Enroll □ Decline	□ Avesis Vision Coverage	□ Applicant Only $4.07 □ Applicant + Spouse $13.20 □ Applicant + Child $13.02 □ Applicant & Family $16.42

DENTAL PLANS– PER MONTH PREMIUMS LISTED

ACTION	PROVIDER	COVERAGE LEVEL
□ Enroll □ Decline	□ Cigna Dental HMO	□ Applicant Only $36.66 □ Applicant + Spouse $77.14 □ Applicant + Child $61.69 □ Applicant & Family $120.63
□ Enroll □ Decline	□ Delta Dental PPO Plus Premier	□ Applicant Only $8.69 □ Applicant + Spouse $17.38 □ Applicant + Child $16.92 □ Applicant & Family $26.05

FIRST PAYMENT FOR CONTIUATION COVERAGE

- If you elect continuation coverage, you do not need to send payment with the Enrollment Form.
- **Your first payment is due (i.e., must be postmarked) no later than 45 days after the date your Enrollment Form was postmarked (or faxed, or scanned) and sent to ADOA – Benefit Services Division.**
- Keep in mind that your Enrollment Form will not be processed, and your COBRA coverage will not become effective, until payment is made in full. Further, if you fail to make your first payment within the 45 days allotted, you will lose all continuation coverage rights under the Plan.
- If payment is made on time (as indicated above), COBRA continuation coverage will begin the day after your job-based coverage ended.
- You are responsible for making sure that the amount of your first payment is correct.
- You may contact ADOA – Benefit Services Division at (602) 542-5008 or (800) 304-3687 to confirm the correct amount of your first payment.

MONTHLY PAYMENTS FOR CONTIUATION COVERAGE

- After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments thereafter.
- The amount due per month for each qualified beneficiary will be sent to you in a billing statement from ADOA – HITF.
- If you make a full payment on or before the due date, your continuation coverage under the Plan will continue for another month without a break.
- Billing statements are mailed as a courtesy. If you do not receive a bill, you may call ADOA – Benefit Services Division for assistance.

PAYMENTS – WHERE AND HOW TO SEND

All payments for COBRA continuation coverage shall be made by check or money order and made out to: Arizona Department of Administration – HITF	**Send your payments to:** Arizona Department of Administration – Health Insurance Trust Fund (HITF) 100 N. 15th Ave., Suite 302 Phoenix, AZ 85007

EXTENSION OF COBRA COVERAGE

- If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled, or if a second qualifying life event occurs.
- You must notify the ADOA – Benefit Services Division of a disability or a second qualifying life event immediately to extend the period of continuation coverage.
- Failure to provide notice to the ADOA – Benefit Services Division of a disability or second qualifying event may affect your right to extend the period of continuation coverage.
- Please contact Benefit Services for additional information if you have experienced a qualifying life event.

AUTHORIZATION AND SIGNATURE

I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true. 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, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of the Affordable Care Act (ACA).

Signature: _____ **Date**: ___/___/____

electronic signatures not accepted

Return by mail, fax or email to: ADOA, Benefit Services Division, 100 N. 15th Ave., Suite 260, Phoenix, AZ 85007
phone: 602-542-5008 | benefitsissues@azdoa.gov | fax: 602-542-4744 | benefitoptions.az.gov