

APPLICANT INFORMATION

REQUIRED INFORMATION	Applicant Last Name			Applicant First Name		Applicant Middle Initial	
	Applicant State of AZ EIN (if applicable)		Applicant SSN	Applicant Sex <input type="checkbox"/> M <input type="checkbox"/> F	Applicant Date of Birth		
	Applicant Street Address			Applicant City		Applicant ST	Applicant ZIP
	Applicant Home Phone		Applicant Cell Phone		Applicant Email		
	Employee Last Name		Employee First Name		Employee MI	Employee EIN	Employee SSN
	Select all that apply: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Address Change			<input type="checkbox"/> Qualified Life Event* <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Terminate Coverage		QUALIFIED LIFE EVENT* <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status	



***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**	MEDICAL (M) DENTAL (D) VISION (V)
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> Add <input type="checkbox"/> Drop				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V

FOR RELATIONSHIP- YOU MUST WRITE **SPOUSE, CHILD, STEPCHILD, PLACED FOR ADOPTION, OR GUARDIAN.

MEDICAL PLANS– PER MONTH PREMIUMS LISTED

ACTION***	PLAN TYPE	PROVIDER	COVERAGE LEVEL
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	<input type="checkbox"/> EPO	<input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross Blue Shield of AZ <input type="checkbox"/> Cigna <input type="checkbox"/> UnitedHealthcare	<input type="checkbox"/> Applicant Only \$676.69 <input type="checkbox"/> Applicant + Spouse \$1431.64 <input type="checkbox"/> Applicant + Child \$956.53 <input type="checkbox"/> Applicant & Family \$1670.18
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	<input type="checkbox"/> PPO	<input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross Blue Shield of AZ <input type="checkbox"/> UnitedHealthcare	<input type="checkbox"/> Applicant Only \$756.62 <input type="checkbox"/> Applicant + Spouse \$1,599.11 <input type="checkbox"/> Applicant + Child 1,070.22 <input type="checkbox"/> Applicant & Family 1,865.77
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	<input type="checkbox"/> HDHP	<input type="checkbox"/> Aetna	<input type="checkbox"/> Applicant Only \$449.82 <input type="checkbox"/> Applicant + Spouse \$953.02 <input type="checkbox"/> Applicant + Child \$636.24 <input type="checkbox"/> Applicant & Family \$1,111.31



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

¹Social 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.
NOTE: See NAU Blue Cross Blue Shield Plan rates at <http://hr.nau.edu/m/content/view/102/112>

ADOA USE ONLY

COBRA EFFECTIVE: __/__/__

LENGTH OF COBRA: _____

VISION PLAN—PER MONTH PREMIUMS LISTED

ACTION	PROVIDER	COVERAGE LEVEL
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	<input type="checkbox"/> Avesis Vision Coverage	<input type="checkbox"/> Applicant Only \$4.07
		<input type="checkbox"/> Applicant + Spouse \$13.20
		<input type="checkbox"/> Applicant + Child \$13.02
		<input type="checkbox"/> Applicant & Family \$16.42

DENTAL PLANS— PER MONTH PREMIUMS LISTED

ACTION	PROVIDER	COVERAGE LEVEL
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	<input type="checkbox"/> Cigna Dental HMO	<input type="checkbox"/> Applicant Only \$8.69
		<input type="checkbox"/> Applicant + Spouse \$17.38
		<input type="checkbox"/> Applicant + Child \$16.92
		<input type="checkbox"/> Applicant & Family \$26.05
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline	<input type="checkbox"/> Delta Dental PPO Plus Premier	<input type="checkbox"/> Applicant Only \$36.66
		<input type="checkbox"/> Applicant + Spouse \$77.14
		<input type="checkbox"/> Applicant + Child \$61.69
		<input type="checkbox"/> Applicant & Family \$120.63

FIRST PAYMENT FOR CONTINUATION 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 CONTINUATION COVERAGE (INITIAL REQUIRED)

- 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.
- **NOTICE: YOU ARE SUBJECT TO TERMINATION, WITHOUT NOTICE AT ANYTIME, FOR NON-PAYMENT OF PREMIUMS IF THE BALANCE DUE IS NOT PAID IN FULL BY THE DUE DATE. _____ (INITIAL REQUIRED)**

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
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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.

APPLICATION – WHERE TO SEND

Return application by email, fax or mail to: ADOA – Health Insurance Trust Fund (HITF), 100 N. 15th Ave., Suite 302, Phoenix, AZ 85007
phone: 602-542-5008 | benefitsissues@azdoa.gov | fax: 602-542-4744 | benefitoptions.az.gov

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