

Benefit Options

Choice. Value. Health.

STATE OF ARIZONA COBRA Premium Assistance OPEN ENROLLMENT/CHANGE FORM 2009-2010

B1

2009-2010 COBRA WITH PREMIUM ASSISTANCE OPEN ENROLLMENT FORM

The new American Recovery and Reinvestment Act of 2009, which the President signed into law on February 17, 2009, includes a 65 percent reduction on the cost of COBRA premiums for up to 9 months.

I DECLINE COBRA COVERAGE AND PREMIUM ASSISTANCE*

**By declining/waiving my rights to COBRA coverage, I understand that I will not be permitted to select COBRA coverage for this qualified life event.*

I AM CURRENTLY ENROLLED IN COBRA AND DECLINE PREMIUM ASSISTANCE

FOR AGENCY USE ONLY - DO NOT WRITE IN THE SHADED AREAS

INVOLUNTARY TERMINATION DATE	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE
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MEMBER IDENTIFICATION

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

- The loss of employment was due to an involuntary termination. Yes No
- The loss of employment occurred between September 1, 2008 and December 31, 2009. Yes No
- Individuals listed on this enrollment form are NOT eligible for other group health plan coverage. Yes No
- Individuals listed on this enrollment form are NOT eligible for Medicare. Yes No

MEDICAL PLANS (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"/> \$186.71		<input type="checkbox"/> \$396.27		<input type="checkbox"/> \$373.42		<input type="checkbox"/> \$514.79
AMERIBEN EPO		<input type="checkbox"/> \$186.71		<input type="checkbox"/> \$396.27		<input type="checkbox"/> \$373.42		<input type="checkbox"/> \$514.79
AETNA EPO		<input type="checkbox"/> \$186.71		<input type="checkbox"/> \$396.27		<input type="checkbox"/> \$373.42		<input type="checkbox"/> \$514.79
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$186.71		<input type="checkbox"/> \$396.27		<input type="checkbox"/> \$373.42		<input type="checkbox"/> \$514.79

PPO PLANS

AMERIBEN PPO		<input type="checkbox"/> \$283.82		<input type="checkbox"/> \$587.62		<input type="checkbox"/> \$562.99		<input type="checkbox"/> \$764.69
AETNA PPO		<input type="checkbox"/> \$283.82		<input type="checkbox"/> \$587.62		<input type="checkbox"/> \$562.99		<input type="checkbox"/> \$764.69
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$283.82		<input type="checkbox"/> \$587.62		<input type="checkbox"/> \$562.99		<input type="checkbox"/> \$764.69

HSA OPTION

AETNA HSA OPTION		<input type="checkbox"/> \$167.43		<input type="checkbox"/> \$352.00		<input type="checkbox"/> \$334.87		<input type="checkbox"/> \$461.60
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DENTAL PLANS (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"/> \$3.56		<input type="checkbox"/> \$6.76		<input type="checkbox"/> \$9.89
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$12.43		<input type="checkbox"/> \$27.79		<input type="checkbox"/> \$47.06

VISION PLAN (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"/> \$1.73		<input type="checkbox"/> \$4.83		<input type="checkbox"/> \$6.02

ADOA USE ONLY

APPROVED

DENIED

COBRA EFF: _____

Length of COBRA: _____

Vendors: _____

Date to Vendors: _____

Reviewed by: _____

Revised 08/12/09

**STATE OF ARIZONA COBRA
Premium Assistance
OPEN ENROLLMENT/CHANGE FORM
2009-2010 CONTINUED**

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Effective January 1, 2009, Social Security numbers (SSN) will be required for primary members and all 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.

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)	SSN	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	REQUIRED	REQUIRED			Y OR N	Y OR N	A OR D	
Employee			S- Spouse C- Child D- Domestic Partner G- Guardian P- Placed for adoption T- Stepchild					
Spouse or Domestic Partner			<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

I affirm that I am eligible for COBRA and premium assistance due to an involuntary termination occurring between September 1, 2008 and December 31, 2009. I am not eligible for any other group health plan or Medicare. I have not previously waived my right to the premium assistance offered by the State of AZ or any other employer. I hereby certify 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, monetary penalties, 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

For additional COBRA help or to view pertinent frequently asked questions please visit: www.benefitoptions.az.gov/cobrafaq