Benefit Options
Choice. Value. Health.

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD ENROLLMENT FORM 2009-2010

☐ NEW RETIREE ☐ NEW LTD PARTICIPANT ☐ ADDRESS CHANGE

☐ QUALIFIED LIFE EVENT ☐ TERMINATE INSURANCE

☐ RETIRED ☐ DISABLED

☐ SURVIVING SPOUSE

EFFECTIVE DATE:

Retirement System

☐ ASRS (ZA) ☐ PSPRS, CORP, EORP (ZP) ☐ OPTIONAL (ZT)

MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	DATE OF BIRTH
STREET ADDRESS	COUNTY OF RESIDENCE	CITY, STATE, ZIP CODE		

LAST DAY WORKED	DATE RETIRED	MEDICARE ☐ YES ☐ NO	HOME PHONE NUMBER	AGENCY

Are you enrolling a Domestic Partner? (circle one) Yes or No

To qualify a 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*.

DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH *(Required)*	RELATIONSHIP CODE S=Spouse D=Domestic Partner C=Child G=Guardian P=Placed for adoption T=Stepchild	MEDICARE A=Medicare A B=Medicare B C=Medicare A & B D=Medicare Unknown E=No Medicare	SOCIAL SECURITY NUMBER *(Required)*	MALE OR FEMALE M OR F	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
MEMBER:							☐ M ☐ D ☐ V
SPOUSE OR DOMESTIC PARTNER:							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V

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FOR ALL MEMBERS

VISION PLAN SELECTION - ONLY AVAILABLE IF MEDICAL AND/OR DENTAL COVERAGE IS SELECTED

VISION PLAN - MARK APPROPRIATE BOX

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

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
Avesis	☐ $4.83	☐ $13.52	☐ $16.86

DENTAL PLANS - MARK APPROPRIATE BOX

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

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
Delta Dental	☐ $34.82	☐ $77.85	☐ $131.82
Total Dental Administrators	☐ $9.96	☐ $18.92	☐ $27.70

MEDICAL PLANS - MARK APPROPRIATE BOX

FOR MEMBERS WITHOUT MEDICARE

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

STATEWIDE PLANS (MONTHLY PREMIUM AMOUNTS)	Retiree Only	Retiree + One	Retiree & Family
EPO PLANS			
CIGNA EPO	☐ $537.00	☐ $1255.00	☐ $1691.00
AETNA EPO	☐ $537.00	☐ $1255.00	☐ $1691.00
AMERIBEN/BCBS of AZ EPO	☐ $537.00	☐ $1255.00	☐ $1691.00
UNITEDHEALTHCARE EPO	☐ $537.00	☐ $1255.00	☐ $1691.00
PPO PLANS			
AETNA PPO	☐ $853.00	☐ $2008.00	☐ $2782.00
AMERIBEN/BCBS of AZ PPO	☐ $853.00	☐ $2008.00	☐ $2782.00
UNITEDHEALTHCARE PPO	☐ $853.00	☐ $2008.00	☐ $2782.00
NAU Only - Available in ALL regions			
BCBS of Arizona PPO	☐ $570.12	☐ $1140.24	☐ $1596.34

****BENEFIT SERVICES DIVISION USE ONLY****

PLAN NAME: _____ PLAN OPTION CODE: _____

****FOR MEMBERS WITH MEDICARE, MAKE ENROLLMENT SELECTIONS ON THE FOLLOWING PAGE****

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FOR MEMBERS WITH MEDICARE - attach a copy of your Medicare card (only if newly electing a Medicare Plan)

☐ I HAVE MEDICARE PART A	☐ I HAVE MEDICARE PART B

MEDICAL PLANS - MARK APPROPRIATE BOX

☐ I DECLINE MEDICAL COVERAGE OR		☐ I ELECT TO KEEP MY CURRENT MEDICAL COVERAGE OR		
STATEWIDE PLANS (MONTHLY PREMIUM AMOUNTS)	**Retiree Only with Medicare**	**Retiree + ONE: Both with Medicare**	**Retiree + ONE: One with Medicare, the other without**	**Retiree + ONE: With Medicare; other dependents without**
EPO PLANS				
CIGNA EPO	☐ $400.00	☐ $795.00	☐ $927.00	☐ $1055.00
AETNA EPO	☐ $400.00	☐ $795.00	☐ $927.00	☐ $1055.00
AMERIBEN/BCBS of AZ EPO	☐ $400.00	☐ $795.00	☐ $927.00	☐ $1055.00
UNITEDHEALTHCARE EPO	☐ $400.00	☐ $795.00	☐ $927.00	☐ $1055.00
PPO PLANS				
AETNA PPO	☐ $714.00	☐ $1426.00	☐ $1575.00	☐ $1792.00
AMERIBEN/BCBS of AZ PPO	☐ $714.00	☐ $1426.00	☐ $1575.00	☐ $1792.00
UNITEDHEALTHCARE PPO	☐ $714.00	☐ $1426.00	☐ $1575.00	☐ $1792.00
NAU Only - Available in ALL Regions				
BCBS of Arizona PPO	☐ $510.55	☐ $1021.36	☐ $1080.93	☐ $1379.41

If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.

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, disciplinary action, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws.

Signature: _____ **Date:** _____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103
Phoenix, AZ 85007

***** BENEFIT SERVICES DIVISION USE ONLY *****

PLAN NAME: _____	PLAN OPTION CODE: _____