

BENEFITS WILL BE EXTENDED FOR UP TO SIX MONTHS

DATE RECEIVED	AGENCY	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		

MEDICAL PLANS (Monthly Cost Listed)

I DECLINE MEDICAL COVERAGE OR

EPO PLANS

SELECT A PLAN	CODE	DP ONLY	CODE	DP + CHILD	CODE	DP + FAMILY
AETNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
BCBS of AZ/AMERIBEN EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
CIGNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52

PPO PLANS

AETNA PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
BCBS of AZ/AMERIBEN PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30

HSA OPTION

AETNA HSA OPTION		<input type="checkbox"/> \$539.58		<input type="checkbox"/> \$1079.16		<input type="checkbox"/> \$1487.16
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DENTAL PLANS (Monthly Cost Listed)

I DECLINE DENTAL COVERAGE OR

SELECT A PLAN	CODE	DP ONLY	CODE	DP + ONE	CODE	DP + FAMILY
DELTA DENTAL PPO PLUS PREMIER IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$36.66		<input type="checkbox"/> \$82.41		<input type="checkbox"/> \$139.56
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$10.16		<input type="checkbox"/> \$19.30		<input type="checkbox"/> \$28.25

VISION PLAN (Monthly Cost Listed)

I DECLINE VISION COVERAGE OR

SELECT A PLAN	CODE	DP ONLY	CODE	DP + ONE	CODE	DP + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$4.93		<input type="checkbox"/> \$13.79		<input type="checkbox"/> \$17.20

BENEFITS WILL BE EXTENDED FOR UP TO SIX MONTHS

Effective January 1, 2009, Social Security numbers (SSN) are required for you and your 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)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	ADD OR DELETE	INDICATE PLAN TYPE MEDICAL(M) DENTAL(D) VISION(V)
REQUIRED	REQUIRED	REQUIRED			A OR D	
Opposite-Sex Domestic Partner						
Opposite Sex Domestic Partner Child(ren)			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			Opposite-Sex Domestic Partner's Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V

EMPLOYEE AUTHORIZATION AND SIGNATURE

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, disciplinary action, 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