Benefit Options
Choice. Value. Health.

STATE OF ARIZONA ACTIVE 2011 OPEN ENROLLMENT FORM

ONLY COMPLETE THIS FORM IF MAKING CHANGES TO YOUR CURRENT COVERAGE

DATE RECEIVED	AGENCY	EFFECTIVE DATE

☐ **OPEN ENROLLMENT** ☐ **NEW EMPLOYEE** ☐ **QUALIFIED LIFE EVENT** ☐ **ADDRESS CHANGE** ☐ **TERMINATION**

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN	EMPLOYEE SSN	☐ MALE ☐ FEMALE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	
CITY, STATE, ZIP CODE	WORK PHONE NUMBER	HOME PHONE NUMBER	

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

To qualify a same-sex 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.

MEDICAL PLANS (Employee Per Pay Period Cost Listed)

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

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
EPO PLANS								
CIGNA EPO		☐ $18.46		☐ $54.92		☐ $46.62		☐ $102
AMERIBEN/BCBS of AZ EPO		☐ $18.46		☐ $54.92		☐ $46.62		☐ $102
AETNA EPO		☐ $18.46		☐ $54.92		☐ $46.62		☐ $102
UNITEDHEALTHCARE EPO		☐ $18.46		☐ $54.92		☐ $46.62		☐ $102
PPO PLANS								
AMERIBEN/BCBS of AZ PPO		☐ $71.54		☐ $161.54		☐ $152.77		☐ $224.31
AETNA PPO		☐ $71.54		☐ $161.54		☐ $152.77		☐ $224.31
UNITEDHEALTHCARE PPO		☐ $71.54		☐ $161.54		☐ $152.77		☐ $224.31
HSA OPTION								
AETNA HSA		☐ $12		☐ $47.08		☐ $37.38		☐ $89.08

DENTAL PLANS(Employee Per Pay Period Cost Listed)

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

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		☐ $2.31		☐ $4.15		☐ $6.46
DELTA DENTAL INDEMNITY/PPO		☐ $14.30		☐ $32.71		☐ $56.82

VISION PLAN (Employee Per Pay Period Cost Listed)

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

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		☐ $2.23		☐ $6.24		☐ $7.78

Effective January 1, 2009, all Active State employees will be required to provide social security numbers (SSNs) for their 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.

REVISED 10/20/10

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DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)	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)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER	**REQUIRED**	**REQUIRED**			A OR D	
Employee			S- Spouse C- Child D- Same-Sex Domestic Partner G- Guardian P- Placed for adoption T- Stepchild			
Spouse or Same-Sex Domestic Partner			☐ S ☐ D	☐ M ☐ F		☐ *M* ☐ *D* ☐ *V*
			☐ C ☐ G ☐ P ☐ T	☐ M ☐ F		☐ *M* ☐ *D* ☐ *V*
			☐ C ☐ G ☐ P ☐ T	☐ M ☐ F		☐ *M* ☐ *D* ☐ *V*
			☐ C ☐ G ☐ P ☐ T	☐ M ☐ F		☐ *M* ☐ *D* ☐ *V*
			☐ C ☐ G ☐ P ☐ T	☐ M ☐ F		☐ *M* ☐ *D* ☐ *V*
			☐ C ☐ G ☐ P ☐ T	☐ M ☐ F		☐ *M* ☐ *D* ☐ *V*

SHORT-TERM DISABILITY

The Hartford Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay $0.70 for every $100 of earned income per month. Please visit www.benefitoptions.az.gov for more information regarding Short-Term Disability coverage.

☐ **I DECLINE SHORT-TERM DISABILITY** ☐ **I ELECT SHORT-TERM DISABILITY**

SUPPLEMENTAL LIFE INSURANCE

Supplemental coverage is available in increments of $5,000. Your cost for Supplemental Life and AD&D insurance is based on your age as of January 1st (the first day of the plan year). Premiums for Supplemental Life coverage above $35,000 are paid on an after-tax basis. You may elect to increase your Supplemental Life coverage during Open Enrollment.

☐ **I DECLINE SUPPLEMENTAL LIFE INSURANCE** ☐ **I ELECT TO KEEP MY CURRENT SUPPLEMENTAL LIFE INSURANCE**

Total amount of employee coverage: $_____

DEPENDENT LIFE INSURANCE

☐ **I DECLINE DEPENDENT LIFE INSURANCE** ☐ **I ELECT TO KEEP MY CURRENT DEPENDENT LIFE INSURANCE**

☐ **$2,000**	**$0.94/MONTH**	**Plan Code 02**	☐ **$12,000**	**$5.64/MONTH**	**Plan Code 12**
☐ **$4,000**	**$1.88/MONTH**	**Plan Code 04**	☐ **$15,000**	**$7.05/MONTH**	**Plan Code 15**
☐ **$6,000**	**$2.82/MONTH**	**Plan Code 06**	☐ **$50,000**	**$24.25/MONTH**	**Plan Code 50**

Beneficiary Last Name, First Name	Date of Birth
Beneficiary Street, City, State, Zip Code	

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify that 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

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