Benefit Options
Choice. Value. Health.

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD 2011 ENROLLMENT FORM

☐ NEW RETIREE ☐ NEW LTD PARTICIPANT ☐ ADDRESS CHANGE

☐ QUALIFIED LIFE EVENT ☐ TERMINATE INSURANCE

☐ RETIRED ☐ DISABLED ☐ SURVIVING SPOUSE	Retirement System ☐ ASRS (ZA) ☐ PSPRS, CORP, EORP (ZP) ☐ OPTIONAL (ZT)	
EFFECTIVE DATE:	DECEASED MEMBER'S NAME:	DECEASED DATE:

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 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* .

DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH *(Required)*	RELATIONSHIP CODE S=Spouse D=Same-Sex 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 SAME-SEX 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 - MONTHLY PREMIUMS AMOUNT

☐ DECLINE VISION COVERAGE OR

Select A Plan (only if changing)	Retiree Only	Retiree + One	Retiree & Family
Avesis	☐ $4.83	☐ $13.52	☐ $16.86

DENTAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ DECLINE DENTAL COVERAGE OR

Select A Plan (only if changing)	Retiree Only	Retiree + One	Retiree & Family
Delta Dental PPO Plus Premier	☐ $35.94	☐ $80.79	☐ $136.82
Total Dental Administrators	☐ $9.96	☐ $18.92	☐ $27.70

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT

FOR MEMBERS WITHOUT MEDICARE

☐ DECLINE MEDICAL COVERAGE OR

Select A Plan (only if changing)	Retiree Only	Retiree + One	Retiree & Family
EPO PLANS			
AETNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
BCBS of AZ/AMERIBEN EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
CIGNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
UNITEDHEALTHCARE EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
PPO PLANS			
AETNA PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
BCBS of AZ/AMERIBEN PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
UNITEDHEALTHCARE PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
NAU Only - Available in ALL regions			
BCBS of Arizona PPO	☐ $606.42	☐ $1212.84	☐ $1697.99

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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STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD 2011 ENROLLMENT FORM

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 - MONTHLY PREMIUMS AMOUNT

☐ DECLINE MEDICAL COVERAGE OR		☐ KEEP MY CURRENT MEDICAL COVERAGE OR		
Select A Plan (only if changing)	**Retiree Only with Medicare**	**Retiree + ONE: Both with Medicare**	**Retiree + ONE: One with Medicare, the other without**	**Retiree & Family With Medicare**
EPO PLANS				
AETNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
BCBS of AZ/AMERIBEN EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
CIGNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
UNITEDHEALTHCARE EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
PPO PLANS				
AETNA PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
BCBS of AZ/AMERIBEN PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
UNITEDHEALTHCARE PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
NAU Only - Available in ALL Regions				
BCBS of Arizona PPO	☐ $543.06	☐ $1086.39	☐ $1149.76	☐ $1467.24

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: _____