2016 Benefit Options Open Enrollment Form - Retiree

Arizona Department of Administration
Benefit Options
Benefit Services Division

REQUIRED

INSURED INFORMATION

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.

Insured Information	Name- Last		First		MI	
	EIN or SSN	Sex ☐M ☐F	Date of Birth	Agency		
Address	Street		City	State	Zip	
Contact Information	Home Phone	Cell Phone	Email	County		

REQUIRED

Select all that apply:

☐ Adding Dependent(s) ☐ Dropping Dependent(s)

☐ Terminate Coverage ☐ Address Change ☐ Name Change

SPOUSE/DEPENDENT INFORMATION *FOR RELATIONSHIP- INDICATE SPOUSE, CHILD, STEPCHILD, PLACED FOR ADOPTION, OR GUARDIAN.*

For Changes Only	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP	MEDICAL (M) DENTAL (D) VISION (V)
☐ Add ☐Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐Drop				☐ M ☐ F		☐ M ☐ D ☐ V

Vision Plan - Monthly Premiums Amount *(Only Available if Medical and/or Dental Coverage is Selected)*

Action	Provider	Coverage Level
□ Enroll □ Decline □ No Change	□ Avesis Vision Coverage	□ Retiree Only ($3.99) □ Retiree + One ($12.94) □ Retiree + Child ($12.76) □ Retiree & Family ($16.10)

Dental Plan - Monthly Premiums Amount

Action	Provider	Coverage Level
□ Enroll □ Decline □ No Change	□ Total Dental Administrators	□ Retiree Only ($8.99) □ Retiree + One ($17.98) □ Retiree + Child ($17.51) □ Retiree & Family ($26.97)
□ Enroll □ Decline □ No Change	□ Delta Dental PPO Plus Premier	□ Retiree Only ($35.94) □ Retiree + One ($75.63) □ Retiree + Child ($60.48) □ Retiree & Family ($118.26)

Medical Plan - Monthly Premiums Amount ***(NON-MEDICARE)***			
Action	Plan Type	Provider	Coverage Level
□ Enroll □ Decline □ No Change	□ EPO	□ Cigna □ United HealthCare □ BCBSAZ □ Aetna	□ Retiree Only ($593.00) □ Retiree + One ($1,387.00) □ Retiree & Family ($1,869.00)
□ Enroll □ Decline □ No Change	□ PPO	□ United HealthCare □ BCBSAZ □ Aetna	□ Retiree Only ($825.00) □ Retiree + One ($2,009) □ Retiree & Family ($2,197)
□ Enroll □ Decline □ No Change	□ PPO - **NAU ONLY**	□ BCBSAZ	□ Retiree Only ($726.41) □ Retiree + One ($1,452.80) □ Retiree & Family ($2,033.95)

For Members with Medicare - You are required to complete the 2016 Group Part D Prescription Drug Enrollment Form (Enclosed)

□ I Have Medicare Part A	□ I Have Medicare Part B

□ I ACCEPT MEDICAL AND PHARMACY COVERAGE - Medicare becomes your primary insurance for medical coverage and includes Medicare Part D prescription drug coverage. I also understand that if I enroll in another Part D Prescription Drug Program I will lose both my prescription drug coverage and my medical coverage.

□ I DECLINE MEDICAL AND PHARMACY COVERAGE

Medical Plan - Monthly Premiums Amount ***(MEDICARE)***			
Action	Plan Type	Provider	Coverage Level
□ Enroll □ Decline □ No Change	□ EPO	□ Cigna □ United HealthCare □ BCBSAZ □ Aetna	□ Retiree Only ($442.00) □ Retiree + One: Both with Medicare ($878.00) □ Retiree + One: One with Medicare, the other without ($1,024.00) □ Retiree & Family with Medicare ($1,166.00)
□ Enroll □ Decline □ No Change	□ PPO	□ United HealthCare □ BCBSAZ □ Aetna	□ Retiree Only ($789.00) □ Retiree + One: Both with Medicare ($1,576.00) □ Retiree + One: One with Medicare, the other without ($1,740.00) □ Retiree & Family with Medicare ($1,980.00)
□ Enroll □ Decline □ No Change	□ PPO **NAU ONLY**	□ BCBSAZ	□ Retiree Only ($591.37) □ Retiree + One: Both with Medicare ($1,183.04) □ Retiree + One: One with Medicare, the other without ($1,317.78) □ Retiree & Family with Medicare ($1,625.77)

1. If you are eligible for Medicare, your medical coverage will include prescription drug coverage in a Medicare Part D plan with additional coverage provided by the State of Arizona.

2. If you are enrolled in another Medicare prescription drug plan or individual Medicare Advantage plan – with or without prescription drug coverage – you will automatically be disenrolled from that coverage. If you enroll in these plans after you are enrolled in the State of Arizona's plan, you will be disenrolled from the State of Arizona plan.

3. If you are disenrolled or otherwise leave the State of Arizona medical or prescription drug plan, you will lose both your medical and prescription drug coverage.

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. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACA).

Member Signature: _____ Date: _____

Dependent/Spouse Signature: _____ Date: _____

Return form to: ADOA, Benefit Services Division, 100 N. 15th Ave., Suite 103 Phoenix, AZ 85007 or fax: 602-542-4744 or email to: benefitsissues@azdoa.gov.

Arizona Department of Administration
Benefit Options
Benefit Services Division