SUBMITTING A NEW RETIREMENT APPLICATION

In order to enroll in ADOA - Benefit Options retiree benefits, please fill out the 2017 Benefit Options Enrollment Form- Retiree.
If you are Medicare eligible and you are enrolling in medical coverage, the Medicare GenerationRx (Employer PDP) Form is also required along with a copy of your Medicare card or a letter of entitlement from Medicare.

ELIGIBLE RETIREES

The following persons are eligible to participate in the Arizona Benefit Options program:

A. Retirees receiving a pension under a State sponsored retirement Plan and continuing enrollment in the Retiree health and/or dental Plan.

B. Long-Term Disability (LTD) participants collecting benefits under a State-sponsored plan.

C. Eligible former elected officials and their eligible dependents if the elected official has at least five years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.

D. Surviving spouses and qualified dependents provided they were covered at the time of the retiree's death.

E. Surviving spouses of former elected officials provided they were covered at the time of the official's death.

F. Surviving spouse and eligible dependents of a deceased law enforcement officer killed in the line of duty whether they were covered or uncovered at the time of death.

G. Surviving spouses and eligible dependents of an active member that is eligible to retire provided they were covered at the time of the employee's death.

SUBMITTING A CHANGE REQUEST

Requested benefit changes must be submitted in writing to ADOA Benefit Services Division within 31 calendar days of the event.

EFFECTIVE DATE OF THE CHANGE

The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event.
The effective date for benefit changes based on all other QLEs is the first day of the next calendar month, following the date the retiree submits the requested change, in writing, to ADOA Benefit Services Division.
Please consult with ADOA Benefit Services Division to determine whether or not the life event you are experiencing qualifies under the regulations.

ELIGIBLE DEPENDENTS

Eligible dependents include:
1. Your legal spouse as defined by Arizona Statute
2. Your child(ren) under 26 years old defined as:
a. Your natural child, adopted child, stepchild, foster child, or a child for whom you have court-ordered guardianship.
b. Your child who is disabled and continues to be disabled as defined by 42 U.S.C. 1382c before the age of 26.

DEPENDENT DOCUMENTATION REQUIREMENTS

If your dependent child is approaching age 26 and has a disability, application for continuation of dependent status must be made within 31 days of the child's 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, that occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.

If you are enrolling a dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation such as a marriage license for a spouse or a birth certificate or court order for a dependent, is provided to the Benefit Services Division. Documentation not received within 31 days of the qualified life event will result in dependent not being enrolled in ADOA benefit plan.

RETURN TO WORK RETIREES

Former retired State employees returning to Active State Employment can receive health benefits through the Benefit Options Health Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving state service is considered a Qualified Life Event (QLE). The QLE then allows them to enroll in retiree benefits again.

BILLING AND PAYMENT INFORMATION - TERMS AND CONDITIONS

Please initial each given section and sign at the bottom.

If you are having your medical and/or dental premiums deducted from your pension, it can take up to 2-3 months for this to appear on your pension. You may receive a billing statement at the end of those 2-3 months for the premiums that are due. It is strongly suggested that if you are a new retiree, that you set aside your first 2-3 months of premiums so that you can pay the balance in full when the billing statement arrives. ADOA is not legally authorized to make any sort of financial payment arrangements and any outstanding balance that is not paid will be referred to the next level of collections required to collect your outstanding debt.

_____ (Initial)

I understand that prorated months of service for medical and/or dental will be billed directly by ADOA and that if I am eligible for a subsidy from my retirement system, that it will not apply to prorated months.

_____ (Initial)

I understand that if I elect Vision coverage, that I must have medical and/or dental coverage as well and that vision is not available as a stand alone coverage. I understand that Avesis Vision will bill me separately and that if I am eligible for a subsidy through my retirement system that it will not apply towards my vision coverage.

_____ (Initial)

I understand that I may receive a billing statement for my medical and/or dental premiums and that the balance is due in full within 30 days from the date on that statement. I agree to pay any and all owed balances in full each month within 30 days of the date on the billed invoice. I understand that if payment is not received in full by the due date that the account may be forwarded to the next level of collections required to collect my outstanding debt.

_____ (Initial)

I understand that if I fail to pay my premiums that my medical, dental, and/or vision coverage may be retroactively terminated and I would be legally responsible for any services/claims received.

_____ (Initial)

I HAVE READ AND UNDERSTAND THIS AGREEMENT, AND I ACCEPT AND AGREE TO ALL OF ITS TERMS AND CONDITIONS. I ENTER INTO THIS AGREEMENT VOLUNTARILY, WITH FULL KNOWLEDGE OF ITS EFFECT.

Member Signature_____ Date_____

(ELECTRONIC SIGNATURE NOT ACCEPTED)

Member Name (Please Print)_____

Arizona Department of Administration
Benefit Options
Benefit Services Division

2017 Benefit Options Retiree/LTD Enrollment Form

Effective Date: _____

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	☐ Married ☐ Single	Medicare? ☐Yes ☐No
Address	Street	City	State	Zip	
Contact Information	Home Phone	Cell Phone	Email	County	

Retirement Information	Name of Agency / University retired from	Last day worked	Retirement Date	Retirement System: ☐ ASRS (ZA) ☐ PSPRS, CORP, EORP (ZP) ☐ OPTIONAL (ZT)
Survivor Information	Name of Deceased Employee or Retiree			Date of Death

Select all that apply: ☐ **New Retiree** ☐ **Surviving Spouse** ☐ **New LTD Participant** ☐ **Open Enrollment 2017**

☐ **Qualifying Life Event (select event below)** **Date of Event:____/_____/_____**

☐ Marriage	☐ Birth/Adoption	☐ Gain/Loss of Other Coverage	☐ Death of spouse/dependent
☐ Address Change	☐ Divorce/Legal Separation	☐ Change in Dependent Eligibility Status	☐ Moved out of plan's service area
☐ Terminate Coverage	☐ OTHER:_____		

SPOUSE/DEPENDENT INFORMATION

For Changes Only	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP CODE Spouse = S Child = C Guardian = G Placed For Adoption = P Stepchild = T	MEDICARE A= Part A B= Part B C= Parts A & B D= Unknown E= None	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

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

Avesis Vision Coverage

☐ **Enroll** ☐ **Decline** ☐ **No Change**

☐ Retiree Only ($3.99) ☐ Retiree + One ($12.94) ☐ Retiree + One Child ($12.76) ☐ Retiree & Family ($16.10)

Dental Plan - Monthly Premiums Amount

Total Dental Administrators

☐ **Enroll** ☐ **Decline** ☐ **No Change**

☐ Retiree Only ($8.99) ☐ Retiree + One ($17.98) ☐ Retiree + One Child ($17.51) ☐ Retiree & Family ($26.97)

Delta Dental PPO Plus Premier

☐ **Enroll** ☐ **Decline** ☐ **No Change**

☐ Retiree Only ($35.94) ☐ Retiree + One ($75.63) ☐ Retiree + One Child ($60.48) ☐ Retiree & Family ($118.26)

If you do not select **Enroll, **Decline**, or **No Change** in each coverage section, the coverage will be automatically declined.

Medical Plan - Monthly Premiums Amount ***(NON-MEDICARE)***

EPO PLAN (select one): □ Aetna □ BCBSAZ □ Cigna □ UnitedHealthcare

□ Enroll □ Decline □ No Change

□ Retiree Only ($593.00) □ Retiree + One ($1387.00) □ Retiree & Family ($1,869.00)

PPO PLAN (select one): □ Aetna □ BCBSAZ □ UnitedHealthcare

□ Enroll □ Decline □ No Change

□ Retiree Only ($825.00) □ Retiree + One ($2,009.00) □ Retiree & Family ($2,197.00)

PPO PLAN - NAU ONLY: □ BCBSAZ

□ Enroll □ Decline □ No Change

□ Retiree Only ($769.99) □ Retiree + One ($1,539.97) □ Retiree & Family ($2,155.99)

For Members with Medicare electing medical - You are required to complete the 2017 Group Part D Prescription Drug Enrollment Form

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

□ ACCEPT MEDICAL AND PHARMACY COVERAGE - Medicare becomes primary for medical coverage and includes Medicare Part D prescription drug coverage. I understand that if I lose my prescription drug coverage, I will also lose my medical coverage.

□ DECLINE MEDICAL AND PHARMACY COVERAGE

Medical Plan - Monthly Premiums Amount ***(MEDICARE)***

EPO PLAN (select one): □ Aetna □ BCBSAZ □ Cigna □ UnitedHealthcare

□ Enroll □ Decline □ No Change

□ 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)

PPO PLAN (select one): □ Aetna □ BCBSAZ □ UnitedHealthcare

□ Enroll □ Decline □ No Change

□ 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)

PPO PLAN - NAU ONLY: □ BCBSAZ (Medicare Generation RX Form NOT required)

□ Enroll □ Decline □ No Change

□ Retiree Only ($626.85) □ Retiree + One: Both with Medicare ($1,254.02)

□ Retiree + One: One with Medicare, the other without ($1,396.85) □ Retiree & Family with Medicare($1,723.32)

PLEASE READ AND INITIAL

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 enroll in the State of Arizona's medical plan and are enrolled in another Medicare prescription drug plan or individual Medicare Advantage plan– with or without prescription drug coverage – you will be disenrolled from that other 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. _____
4. If you are enrolling in the ADOA Benefit Options Medical plan with Medicare (non-NAU), you are required to include a completed Medicare Generation RX form along with this enrollment form. _____

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: _____

(Any spouse/dependent with Medicare coverage with ADOA medical MUST sign; electronic signatures are not accepted)

Return form to: ADOA, Benefit Services Division, 100 N. 15th Ave., Suite 260 Phoenix, AZ 85007 or fax: 602-542-4744 or email to: benefitsissues@azdoa.gov.

Arizona Department of Administration Benefit Options Benefit Services Division