## 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 pay period, following the date the employee 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

A. Your legal spouse

B. Your child defined as:

- a. Your natural, adopted and/or stepchild who is under 26 years old;
- b. A person under the age of 26 for whom you have court-ordered guardianship;
- c. Your foster children under the age of 26;
- d. A child placed in your home by court order pending adoption;
- e. Your natural, adopted and/or stepchild;
  - i. Who was disabled as defined by 42 U.S.C. 1382c before the age of 26;
  - ii. Who continues to be disabled as defined by 42 U.S.C. 1382c;
  - iii. Who is dependent for support and maintenance upon you;
  - iv. For whom you had custody before the child was 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.

## CHANGING YOUR BENEFITS

You may change your benefit elections during the year only when you experience a Qualified Life Event (QLE). Changes permitted are dependent on the QLE. Contact member services or review your Benefit Guide Book and/or plan description regarding what changes are permitted. If you have not experienced a QLE, you must wait until the next annual open enrollment period to make changes. Qualifying Life Events include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse;
- Changes in dependent status: birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, and student status;
- Changes in employment status or work schedule that affect benefit eligibility for you, your spouse, and/or dependent
- Changes in residence that result in different available plan options

**Note: A Qualified Life Event (QLE) application must be submitted with all supporting documentation within 31 days of the QLE.**

## SUPPORTING DOCUMENTATION

ADOA requires proof of the qualifying life event. Examples of the documentation needed would be:

**Marriage:** marriage certificate

**Divorce:** divorce decree

**Birth:** birth certificate, crib card, or hospital verification letter

**Legal Separation:** legal separation documents

**Adoption/Placement for Adoption:** legal adoption papers

**Death of Spouse or Dependent:** Death Certificate

**Loss or Gain of Coverage:** letter from employer or health, dental, vision plans with date coverage ended/started

For more information, please vist our website **http://benefitoptions.az.gov/**

Questions? Please contact your agency's human resources liasion or contact ADOA - Benefit Services at **602-542-5008** or by e-mail at **benefitsissues@azdoa.gov**.

Arizona Department of Administration
Benefit Options
Benefit Services Division

# 2017 Benefit Options Enrollment Form - Active Employee

Date Received:_____ Effective Date: _____

Arizona Department of Administration
Benefit Options
Benefit Services Division

REQUIRED

## INSURED INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| **Insured Information** | Name- Last | | First | | MI | |
| | Employee EIN | Employee 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:**

☐ New Enrollment ☐ 2017 Open Enrollment

☐ Other _____ ☐ Qualifying Life Event (select event in next box)

☐ Mind Change (Please Write MIND CHANGE At Top Of Form As Well)

**Qualifying Life Event** **Date of Event:____/_____/_____**

☐ Marriage ☐ Gain/Loss of Other Coverage

☐ Birth/Adoption ☐ Death of spouse/dependent

☐ Divorce/Legal Separation ☐ Moved out of plan's service area

☐ Change in Dependent Eligibility Status ☐ Other _____

***FOR QUALIFIED LIFE EVENTS: THIS FORM MUST BE SUBMITTED, ALONG WITH REQUIRED DOCUMENTATION WITHIN 31 DAYS OF THE QUALIFIED LIFE EVENT.**

## SPOUSE/DEPENDENT INFORMATION

| 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 |

FOR RELATIONSHIP- YOU MUST MARK **SPOUSE**, **CHILD**, **STEPCHILD**, **PLACED** FOR ADOPTION, OR **GUARDIAN**.

## Medical Plans - Employee Per Pay Period Cost Listed (26 Pay Periods)

**EPO PLAN (select one): ☐ Aetna ☐ BCBS AZ ☐ Cigna ☐ United HealthCare**

**☐ Enroll ☐ Decline ☐ No Change**

☐ Employee Only ($18.46) ☐ Employee + Spouse ($54.92) ☐ Employee + One Child ($46.62) ☐ Family ($102.00)

**PPO PLAN (select one): ☐ Aetna ☐ BCBS AZ ☐ United HealthCare**

**☐ Enroll ☐ Decline ☐ No Change**

☐ Employee Only ($47.08) ☐ Employee + Spouse ($99.23) ☐ Employee + One Child ($66.46) ☐ Family ($115.85)

**HSA PLAN: ☐ Aetna**

**☐ Enroll ☐ Decline ☐ No Change**

☐ Employee Only ($9.23) ☐ Employee + Spouse ($27.69) ☐ Employee + One Child ($23.54) ☐ Family ($51.23)

**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.

## Vision Plan - Employee Per Pay Period Cost Listed (26 Pay Periods)

### Avesis Vision Coverage

□ **Enroll** □ **Decline** □ **No Change**

□ Employee Only ($1.84) □ Employee + Spouse ($5.97) □ Employee + One Child ($5.89) □ Family ($7.43)

## Dental Plans - Employee Per Pay Period Cost Listed (26 Pay Periods)

### Total Dental Administrators

□ **Enroll** □ **Decline** □ **No Change**

□ Employee Only ($1.86) □ Employee + Spouse ($3.72) □ Employee + One Child ($3.50) □ Family ($6.12)

### Delta Dental PPO Plus Premier

□ **Enroll** □ **Decline** □ **No Change**

□ Employee Only ($14.30) □ Employee + Spouse ($30.33) □ Employee + One Child ($23.34) □ Family ($48.26)

## Short Term Disability (26 Pay Periods)

**The Hartford Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay $0.65 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 (26 Pay Periods- premiums vary depending on age- see benefit guidebook for rates)

**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). The maximum amount for Suplemental Life is 3 times your salary up to $500,000. 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. Your deductions may differ slightly due to rounding.**

☐ **I DECLINE SUPPLEMENTAL LIFE INSURANCE**

☐ **I ELECT SUPPLEMENTAL LIFE INSURANCE, TOTAL AMOUNT OF EMPLOYEE COVERAGE: $_____**

## Dependent Life Insurance - Employee Per Pay Period Cost Listed (26 Pay Periods)

☐ **I DECLINE DEPENDENT LIFE INSURANCE**

☐ **$2,000 ($0.43)** ☐ **$4,000 ($0.87)** ☐ **$6,000 ($1.30)** ☐ **$10,000 ($2.17)** ☐ **$12,000 ($2.60)**
☐ **$15,000 ($3.25)** ☐ **$50,000* ($10.85)**

*To qualify for $50,000 you must elect a minimum of $35,000 in Supplemental Life Insurance.

## Beneficiary Information

| Beneficiary Last Name, First Name | Beneficiary Date of Birth | Beneficiary SSN | Beneficiary Contact Number |
|---|---|---|---|
| | | | |

Beneficiary Street, City, State, Zip Code

SIGNATURE REQUIRED

## 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 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. I authorize my employer to reduce my salary by applicable pre-tax dollars or reduce my paycheck by the applicable after-tax dollars for the insurance programs which I have elected. In addition, I have read and understand the declarations. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACA).**

**Signature:** _____ **Date:** _____

(signature must be handwritten/physical; 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