ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2018 Benefit Options Enrollment Form – Active Employee

INSTRUCTIONS

SUBMITTITING A CHANGE REQUEST

Benefit change requests must be submitted in writing to ADOA Benefit Services Division **within 31 calendar days of the event**.

EFFECTIVE DATE OF THE CHANGE

A) **The date of the event -** for benefit changes resulting from birth, adoption, or placement for adoption.
B) **The first day of the pay period** - following the date the employee submits the requested change in writing to ADOA Benefit Services Division. This is the rule for all other QLEs (except birth, adoption, or placement for adoption, as per item A).

Please consult with ADOA Benefit Services Division to determine whether your life event qualifies under the regulations.

ELEGIBLE DEPENDENTS

An eligible dependent includes:

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, child for whom you have court-ordered guardianship, or child placed in your home by court order pending adoption.
   b. Your child who is disabled and continues to be disabled as defined by 42 U.S.C. 1382c before age 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 DUE TO A QUALIFIED LIFE EVENT (QLE)

You may change your benefit elections during the year only when you experience a Qualified Life Event (QLE). 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:

- Marriage, divorce, legal separation, annulment, death of spouse;
- Birth, adoption, placement for adoption, guardianship, dependent eligibility due to limited age, death of a dependent child, change in legal custody.
- Change in employment status or work schedule that affects benefits eligibility for you and/or your dependents.

Newborn Coverage

- Your newborn is ONLY covered under your insurance for the **first 31 days** after birth.
- **Before the 31st day**, you must ENROLL your newborn as a dependent or the child will not have coverage.
- You will have to wait to enroll until the next Open Enrollment or Qualified Life Event.

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
- **Legal Separation**: legal separation documents
- **Death of Spouse/Dependent**: death certificate
- **Birth**: birth certificate, crib card, hospital verification letter
- **Adoption/Placement for Adoption:** legal adoption papers
- **Loss/Gain of Other Coverage:** letter from employer or health, dental, vision plans with date coverage ended/started

Questions? Please contact your agency's human resources liaison or ADOA - Benefit Services at 602-542-5008 or by e-mail at benefitsissues@azdoa.gov. For more information, please visit benefitoptions.az.gov

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INSURED INFORMATION

REQUIRED INFORMATION

Employee Name-Last		First		MI	
Employee EIN	Employee SSN	Sex ☐M ☐F	Date of Birth ___/___/_____	Agency	
Street		City		State	Zip
Home Phone	Cell Phone	Email		County	

Select all that apply
- ☐ New Enrollment
- ☐ Adding Dependent(s)
- ☐ Address Change
- ☐ Qualifying Life Event
- ☐ Dropping Dependent(s)
- ☐ Terminate Coverage

QUALIFIED LIFE EVENT* **Date of Event: ___/___/____**
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Gain/Loss of Other Coverage
- ☐ Death of Spouse/Dependent
- ☐ Moved out of plan's service area
- ☐ Change in Dependent Eligibility Status

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

SPOUSE/DEPENDENT INFORMATION

ACTION	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)[1]	DATE OF BIRTH	SEX	RELATIONSHIP[2]	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

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

MEDICAL PLANS – EMPLOYEE PER PAY PERIOD COST LISTED (26 PAY PERIODS)

ACTION	PLAN TYPE	PROVIDER	COVERAGE LEVEL
☐ Enroll ☐ Decline	☐ EPO	☐ Aetna ☐ Blue Cross Blue Shield of AZ ☐ Cigna ☐ UnitedHealthcare	☐ Employee Only $20.31 ☐ Employee + Spouse $60.42 ☐ Employee + Child $51.28 ☐ Employee & Family $112.20
☐ Enroll ☐ Decline	☐ PPO	☐ Aetna ☐ Blue Cross Blue Shield of AZ ☐ UnitedHealthcare	☐ Employee Only $51.78 ☐ Employee + Spouse $109.15 ☐ Employee + Child $73.11 ☐ Employee & Family $127.43
☐ Enroll ☐ Decline	☐ HDHP High Deductible Health Plan with Health Savings Account	☐ Aetna	☐ Employee Only $10.15 ☐ Employee + Spouse $30.46 ☐ Employee + Child $25.89 ☐ Employee & Family $56.35

****If you do not select ENROLL or DECLINE for EACH coverage: Medical, Dental, and Vision, THE COVERAGE WILL BE DECLINED AUTOMATICALLY.**

[1]***Social Security Numbers:*** *All active State employees are required to provide Social Security Numbers (SSNs) for their enrolled dependents. The SSN is used as the basis for the Medicare Health insurance claim number (HICN). The HICN identifies Medicare beneficiaries receiving health care services, and assists Medicare in its responsibilities to pay for health care and operate the program. 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 & Accountability Act Privacy Rule (HIPPA). Please note that the Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for benefit coordination.*

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VISION PLAN - EMPLOYEE PER PAY PERIOD COST LISTED (26 PAY PERIODS)

ACTION	PROVIDER	COVERAGE LEVEL	
□ Enroll □ Decline	□ Avesis Vision Coverage	□ Employee Only □ Employee + Spouse □ Employee + Child □ Employee & Family	$1.84 $5.97 $5.89 $7.43

DENTAL PLANS - EMPLOYEE PER PAY PERIOD COST LISTED (26 PAY PERIODS)

ACTION	PROVIDER	COVERAGE LEVEL	
□ Enroll □ Decline	□ Cigna Dental HMO	□ Employee Only □ Employee + Spouse □ Employee + Child □ Employee & Family	$1.64 $3.29 $3.08 $5.46
□ Enroll □ Decline	□ Delta Dental PPO Plus Premier	□ Employee Only □ Employee + Spouse □ Employee + Child □ Employee & Family	$14.30 $30.33 $23.34 $48.26

SHORT TERM DISABILITY - EMPLOYEE PER PAY PERIOD COST LISTED (26 PAY PERIODS)

The Hartford Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay $0.18 per pay period 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 - EMPLOYEE PER PAY PERIOD COST LISTED (26 PAY PERIODS)

Supplemental Life and AD&D insurance is available in increments of $5,000. Your cost is based on your age as of January 1 (the first day of the plan year). The maximum amount for Supplemental Life is 3 times your salary up to $500,000. Premiums for coverage above $35,000 are paid on an after-tax basis. You may elect to increase your coverage during Open Enrollment.

☐ **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, MI	Beneficiary Date of Birth ___/___/____	Beneficiary SSN	Beneficiary Contact Number	
Beneficiary Street Address	City		State	Zip Code

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

Signature: ____ **Date:** ___/___/____
electronic signatures not accepted