Benefit Options
Choice. Value. Health.

STATE OF ARIZONA
COBRA (without Premium Assistance)
ENROLLMENT / CHANGE FORM 2008-2009

A1

☐ NEW ENROLLMENT ☐ QUALIFIED LIFE EVENT ☐ ADDRESS CHANGE ☐ TERMINATION

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE

DO NOT WRITE ABOVE THIS LINE - FOR AGENCY USE ONLY

MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	SOCIAL SECURITY NUMBER	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )	
EMPLOYEE LAST NAME, FIRST NAME	EMPLOYEE AGENCY	EMPLOYEE EIN OR SSN	

Are you enrolling a Domestic Partner?(circle one) **Yes or No**

Are you enrolling an Older Child(ren) that is neither a full-time student nor a disabled dependent?(circle one) **Yes or No**

To qualify a Domestic Partner, you will need to complete and submit the *DOMESTIC PARTNER AFFIDAVIT FORM* (this form must be notarized) with your enrollment. To qualify as an Older Child (ages 19 to 25 and neither a full-time student nor a disabled dependent), the Older Child must have been covered on an ADOA plan at the age of 18 years old (see the COBRA Guide for qualifications of an Older Child). These forms can be found on the benefit options website *www.benefitoptions.az.gov*.

MEDICAL PLANS (Monthly Cost Listed)

☐ I DECLINE MEDICAL COVERAGE

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
Counties: Gila, Maricopa, Pima, Pinal, Santa Cruz						
RAN+AMN (HMA) EPO		☐ $485.52		☐ $972.06		☐ $1334.16
UnitedHealthcare (UHC) EPO		☐ $485.52		☐ $972.06		☐ $1334.16
Arizona Foundation (AZF) PPO		☐ $757.86		☐ $1505.52		☐ $2034.90
UnitedHealthcare (UHC) PPO		☐ $757.86		☐ $1505.52		☐ $2034.90
All Other Counties						
RAN+AMN (HMA) EPO		☐ $485.52		☐ $972.06		☐ $1334.16
Arizona Foundation (AZF) PPO		☐ $757.86		☐ $1505.52		☐ $2034.90
OUT-OF-STATE						
Beech Street PPO		☐ $823.14		☐ $1625.88		☐ $2213.40

DENTAL PLANS (Monthly Cost Listed)

☐ I DECLINE DENTAL COVERAGE

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
TOTAL DENTAL ADMINISTRATORS		☐ $10.15		☐ $19.29		☐ $28.25
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		☐ $33.63		☐ $75.49		☐ $127.79

VISION PLAN (Monthly Cost Listed)

☐ I DECLINE VISION COVERAGE

SELECT A PLAN	CODE	Tier 1	CODE	Tier 3
AVESIS VISION COVERAGE		☐ $6.47		☐ $17.52

Revised 03/25/09

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YOUR CONTRIBUTIONS TO BENEFIT OPTIONS

By law, while on COBRA coverage, you will have to pay the total cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families – both the employee's and the employer's portion - plus an additional 2% administrative fee. You must make the first payment within 45 days of notifying the plan administrator of selection of COBRA coverage. The initial payment with your enrollment needs to be sent to ADOA, thereafter, premiums are due on the first day of each month of coverage. After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums. Payments for COBRA coverage are made directly to the individual plan vendors. Each vendor will bill you for your coverage. All payments must be made out to the vendor. ADOA cannot process these payments. ADOA and your vendor will not be able to confirm that you are entitled to covered services until the vendor has received your premium for the month in which the care is to be provided.

Effective January 1, 2009, Social Security numbers (SSN) will be required for you and your active 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.

DEPENDENTS - List all eligible dependents to be enrolled or disenrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)	DATE OF BIRTH (MM/DD/YY)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED	ADD OR DELETE	INDICATE PLAN TYPE MEDICALI(M) DENTAL(D) VISION(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE	**REQUIRED**	**REQUIRED**			**Y OR N**	**Y OR N**	**A OR D**	
Employee			**S- Spouse** **C- Child** **D- Domestic Partner** **G- Guardian** **P- Placed for adoption** **T- Stepchild**					
Spouse or Domestic Partner			☐ S ☐ D	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ ***M*** ☐ ***D*** ☐ ***V***

FLEXIBLE SPENDING

☐ **I DECLINE FLEXIBLE SPENDING**

☐ **I AM ELECTING TO MAINTAIN MEDICAL REIMBURSEMENT**	**MONTHLY AMOUNT $**
☐ **I AM ELECTING TO MAINTAIN DEPENDENT CARE REIMBURSEMENT**	**MONTHLY AMOUNT $**

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/domestic partner 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. In addition, I have read and understand the declarations.

SIGNATURE:_____ **DATE:**_____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 OR FAX TO:602-542-4744

REVISED 03/25/09