



JANICE K. BREWER
Governor

WILLIAM BELL
Director

ARIZONA DEPARTMENT OF ADMINISTRATION

Benefit Services Division

100 N 15TH AVE, SUITE 103
PHOENIX, ARIZONA 85007
(602) 542-5008

Dear MEMBER and ELIGIBLE DEPENDENTS:

This letter is to inform you that, due to a qualifying event, you have lost or will lose your benefits with Benefit Options.

Your right to COBRA coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this qualifying event entitles you to elect continued coverage under the group health plan. You are eligible for COBRA coverage for 18 or 36 months, depending on the nature of the qualifying event.

COBRA coverage is also available to your spouse and dependent children, if they were covered on your plan the day of the qualifying event.

ENROLLMENT PROCEDURES ARE DESCRIBED AT THE END OF THIS LETTER

Your COBRA enrollment options

Your choices are:

- To continue family or two-party coverage, if you had family or two-party coverage on the date of the qualifying event
- For one of more qualifying persons to individually elect single coverage
- For all qualifying persons to decline COBRA coverage entirely.

Duration of COBRA coverage

Your COBRA coverage may terminate early if:

- Health coverage is no longer offered to any active employees.
- You do not make the required payments in a timely manner.
- You, your spouse, or your dependent children become covered under another group health plan that does not effectively limit coverage for any pre-existing condition.
- You, your spouse, or your dependent children become entitled to Medicare.
- Coverage was extended due to disability and the individual is determined to no longer be disabled.

Please refer to the enclosed enrollment forms for current rates and the Benefit Options website (www.benefitoptions.az.gov) for additional information.

**IF YOU WERE INVOLUNTARILY TERMINATED,
YOU MAY BE ELIGIBLE FOR COBRA PREMIUM ASSISTANCE**

PLEASE READ THE INFORMATION PRESENTED BELOW
AS IT DESCRIBES VARIOUS ASPECTS OF COBRA PREMIUM ASSISTANCE,
INCLUDING HOW TO DETERMINE YOUR ELIGIBILITY.

COBRA premium assistance

In accordance with the American Recovery and Reinvestment Act of 2009 (ARRA), which was enacted February 17, 2009, a person who is eligible for COBRA premium assistance will be entitled to COBRA coverage – for a limited time only – at a reduced rate. Under this program, the individual pays 35% of the COBRA premium and the federal government subsidizes the remaining 65%.

Eligibility for premium assistance

You are eligible for COBRA premium assistance if and only if:

- You are eligible for COBRA coverage between September 1, 2008 and December 31, 2009.

AND

- The qualifying event that makes you eligible for COBRA coverage is a covered employee's employment being **involuntarily terminated** between September 1, 2008 and December 31, 2009.

If your employment was not involuntarily terminated, you are not eligible for premium assistance. The Benefit Services Division will request proof of involuntary termination (copy of termination letter or similar document) from the former agency of any former employee who elects COBRA and states that he/she was involuntarily terminated.

Each qualified beneficiary (spouse and child) is entitled to elect COBRA coverage separately and will, if eligible, be entitled to premium assistance.

A domestic partner/older child is not a qualified beneficiary under COBRA, which prevents him/her from electing COBRA coverage separate from the employee. A domestic partner/older child will benefit from premium assistance if the former employee is eligible for and elects premium assistance and:

- The domestic partner/older child was listed as a tax dependent on the former employee's Declaration of Tax Status form.

OR

- The former employee enrolls at least two qualified beneficiaries in COBRA in addition to the domestic partner/older child. Under this scenario, the former employee elects the family tier with or without inclusion of the domestic partner/older child.

Individuals who are eligible for coverage under another group health plan (a spouse's plan, for example) are not eligible for premium assistance. Dependents who lose coverage due to the death or disability of an employee are not eligible for premium assistance.

Disputes regarding your eligibility for premium assistance may be appealed to the Secretary of Health and Human Services. Details related to this appeal process are not available at this time. Please call (602) 542-5008 or (800) 304-3687 if you would like to appeal a decision regarding

your or your dependent's eligibility for premium assistance. You may also check the U.S. Department of Health & Human Services website (www.cms.hhs.gov/COBRACContinuationofCov/) for updates on the appeal process.

COBRA coverage elections

A person receiving premium assistance will be allowed to maintain his/her pre-termination coverages. Premium assistance will apply to his/her medical, dental, and vision coverage (but not to flexible spending accounts).

A person receiving premium assistance will be allowed to change his/her pre-termination coverages if those changes result in a reduced monthly premium compared to the pre-termination monthly premium (i.e., a person could move from a PPO plan to an EPO plan but not from an EPO plan to a PPO plan). If a qualified beneficiary was enrolled in a medical plan on the day of the termination, his/her COBRA elections must include a medical plan in order for the premium assistance to apply (i.e., a person enrolled in both medical and dental will be eligible for premium assistance on both plans as long as he/she continues enrollment in the medical plan; if he/she drops medical coverage, premium assistance will not be available for the dental plan). Any change made will be in effect starting the first day of the month following notification of the change and ending on the last day of COBRA coverage.

Duration of COBRA premium assistance

Premium assistance is available for COBRA payments made for coverage periods beginning on or after February 17, 2009. Those eligible for premium assistance will receive the reduced COBRA rate for up to 9 monthly coverage periods. If a person's COBRA coverage lasts more than 9 months, he/she will have to pay the full COBRA premium to continue coverage.

Eligibility for premium assistance will end earlier if:

- The individual could be covered by another employer's medical plan (even if such coverage is not elected). Under this scenario, premium assistance will not be available for periods of coverage beginning on or after the first date that the individual could actually be covered (without pre-existing condition exclusions) under the other plan.
- The individual becomes eligible for benefits under Title XVIII of the Social Security Act. Premium assistance would end on the date COBRA coverage ends.
- The individual's right to COBRA coverage expires. Premium assistance would end on the date COBRA coverage ends.

Notification responsibility of COBRA premium assistance recipient

A person receiving premium assistance must notify the Benefit Services Division if/when:

- A qualified beneficiary could be covered by another employer's medical plan (even if such coverage is not elected).
- A qualified beneficiary becomes eligible for benefits under Title XVIII of the Social Security Act.

This notification should be provided on Form BN.

In accordance with ARRA, failure to make proper notification may result in a penalty of 110 percent of the subsidized amount received after eligibility is lost. Other details regarding proper

notification are not available at this time. Please call (602) 542-5008 or (800) 304-3687 if you would like more information regarding your responsibility to notify the Benefit Services Division when a qualified beneficiary becomes eligible for other coverage. You may also visit the Benefit Options website (www.benefitoptions.az.gov) beginning March 26, 2009.

Option to decline premium assistance

A person who is eligible for COBRA premium assistance may choose not to receive it.

Enrolling in COBRA coverage

If you are NOT electing premium assistance

You have 60 days from the date on this notice to elect COBRA coverage (without premium assistance). A COBRA enrollment Form A has been included for your convenience. Complete this form and return it to the Benefit Services Division postmarked no later than 60 days from the date on this notice. Your COBRA coverage will begin at the full premium amount. Premium assistance will not be available to you once it is declined.

If you ARE electing premium assistance (you must be eligible)

You have 60 days from the date on this notice to elect COBRA coverage (with premium assistance). A COBRA enrollment Form B has been included for your convenience. To elect COBRA coverage (with premium assistance), complete Form B and return it to the Benefit Services Division postmarked no later than 60 days from the date on this notice.

You will be notified about your approval status within 30 days of the Benefit Services Division receiving a completed Form B.

Declining COBRA coverage

To decline COBRA coverage (with or without premium assistance), return COBRA enrollment Form B with the “I decline COBRA coverage and premium assistance” option marked. COBRA coverage (with or without premium assistance) will not be available to you once it is declined.

If you fail to return an enrollment form, your right to COBRA coverage (with or without premium assistance) will expire after 60 days from the date on this notice.

How premium assistance may affect your eligibility for other assistance programs

Receiving premium assistance will generally not affect eligibility for other assistance programs.

How premium assistance may affect your taxes (high-income taxpayers only)

This provision affects only those with modified adjusted gross incomes of more than \$125,000 (or \$250,000 for those taxpayers filing a joint return).

For tax purposes, COBRA enrollees who receive premium assistance will be provided with documentation detailing how much premium assistance they received in the tax year. Although this process is still under consideration, the information will likely be supplied on a Form W-2 or Form 1099.

Please refer to the following IRS website to learn more about the tax implications of premium assistance: <http://www.irs.gov/newsroom/article/0,,id=205370,00.html>

Additional information

If you have any questions related to COBRA (including premium assistance), please contact:

Samantha Roberts
Arizona Department of Administration - Benefit Services Division
100 N. 15th Avenue, #103
Phoenix, AZ 85007
(602) 542-5008 or (800) 304-3687

This plan is administered by:

Arizona Department of Administration - Benefit Services Division
100 N. 15th Avenue, #103
Phoenix, AZ 85007
(602) 542-5008

Examples of how COBRA premium assistance will be administered will be available on the Benefit Options website (www.benefitoptions.az.gov) beginning March 26, 2009.

Sincerely,

Samantha Roberts
COBRA Analyst

****NOTICE REGARDING YOUR LIFE INSURANCE POLICY****

You may be eligible to continue life insurance coverage through portability or conversion. For more information, visit www.standard.com/mybenefits/arizona/ and click on the "Employee/Beneficiary Forms" link (top left-hand corner of the page). You may also call Standard Insurance Company Continued Benefits at 866-440-4846.

COBRA PAYMENT INFORMATION

<p>How should the first COBRA payment be made?</p>	<ul style="list-style-type: none"> ➤ You must make the first payment within 45 days of submitting a COBRA enrollment form. ➤ You may pay using a check or money order. ➤ Check/money orders should be payable to your carrier: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><i>Carrier</i></th> <th style="text-align: left;"><i>Check/Money Order payable to:</i></th> </tr> </thead> <tbody> <tr> <td>RAN+AMN</td> <td rowspan="3">UMR</td> </tr> <tr> <td>Arizona Foundation</td> </tr> <tr> <td>Beech Street</td> </tr> <tr> <td>UnitedHealthcare</td> <td>UnitedHealthcare</td> </tr> <tr> <td>Delta Dental</td> <td>Delta Dental</td> </tr> <tr> <td>Total Dental</td> <td>Total Dental</td> </tr> <tr> <td>Avesis</td> <td>Avesis</td> </tr> </tbody> </table> <ul style="list-style-type: none"> ➤ First payment should be sent to: <div style="border: 1px solid black; padding: 5px; text-align: center; margin: 10px auto; width: fit-content;"> <p>Benefit Services Division c/o Samantha Roberts 100 N. 15th Avenue, #103 Phoenix, AZ 85007</p> </div>	<i>Carrier</i>	<i>Check/Money Order payable to:</i>	RAN+AMN	UMR	Arizona Foundation	Beech Street	UnitedHealthcare	UnitedHealthcare	Delta Dental	Delta Dental	Total Dental	Total Dental	Avesis	Avesis
<i>Carrier</i>	<i>Check/Money Order payable to:</i>														
RAN+AMN	UMR														
Arizona Foundation															
Beech Street															
UnitedHealthcare	UnitedHealthcare														
Delta Dental	Delta Dental														
Total Dental	Total Dental														
Avesis	Avesis														
<p>Will I have COBRA coverage before making payment?</p>	<ul style="list-style-type: none"> ➤ COBRA coverage is not guaranteed until the first payment is received. ➤ It is important to make your first payment for COBRA as soon as possible and before/on each subsequent payment due date. 														
<p>I don't want to be without coverage. Is it okay to send payment with the enrollment form?</p>	<ul style="list-style-type: none"> ➤ You may send your first payment with your enrollment form. Keep in mind, however, that if you send payment based on the rates listed on enrollment Form B (premium assistance) and the Benefit Services Division determines that you are not eligible for premium assistance, your payment will be returned. 														
<p>How will I know how much I owe?</p>	<ul style="list-style-type: none"> ➤ COBRA rates can be found on the enrollment forms. You may use these rates to calculate your total or you may call Samantha Roberts at (602) 542-5008 or (800) 304-3687. 														
<p>How are subsequent COBRA payments made?</p>	<ul style="list-style-type: none"> ➤ Payments are due on the first day of each month of coverage. ➤ You will receive a bill from your carrier (UMR, UnitedHealthcare, Delta, Total, and/or Avesis). ➤ Should you move, you must inform the Benefit Services Division so it can update your billing address. 														
<p>How often should I pay for COBRA?</p>	<ul style="list-style-type: none"> ➤ Payments are due on the first day of each month of coverage. ➤ You will receive a bill from your carrier. 														
<p>Will I get a bill?</p>	<ul style="list-style-type: none"> ➤ You will not receive a bill for your first payment. ➤ After that you will receive a bill from your carrier. 														

COBRA ENROLLMENT INSTRUCTIONS

	You must act within...	Follow these steps...
<p>COBRA enrollment (<u>without</u> premium assistance)</p>	60 days	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Review the enclosed COBRA information and the information on the website: www.benefitoptions.az.gov <input checked="" type="checkbox"/> Choose your COBRA enrollment options. <input checked="" type="checkbox"/> Complete the enclosed enrollment Form A. <input checked="" type="checkbox"/> Return the enrollment form to the Benefit Services Division at the address below.
<p>COBRA enrollment (<u>with</u> premium assistance)</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>IMPORTANT: You will be notified about your approval status within 30 days of the Benefit Services Division receiving a completed Form B.</i></p> </div>	60 days	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Review the enclosed COBRA information and the information on the website: www.benefitoptions.az.gov <input checked="" type="checkbox"/> Choose your COBRA enrollment options. <input checked="" type="checkbox"/> Complete the enclosed enrollment Form B. <input checked="" type="checkbox"/> Return the enrollment form to the Benefit Services Division at the address below. <input checked="" type="checkbox"/> Complete and return Form BN if you and/or a dependent becomes eligible for another group health plan. A qualified beneficiary may not receive COBRA premium assistance while eligible for another group health plan.

Return all COBRA forms to:	Benefit Services Division 100 N. 15 th Avenue, #103 Phoenix, AZ 85007
For information, please visit:	www.benefitoptions.az.gov www.cms.hhs.gov/COBRAContinuationofCov/
If you have additional questions, please call:	Samantha Roberts (602) 542-5008 or (800) 304-3687

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		<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED
STREET ADDRESS		COUNTY OF RESIDENCE		<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE
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

Counties: Gila, Maricopa, Pima, Pinal, Santa Cruz

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
RAN+AMN (HMA) EPO		<input type="checkbox"/> \$485.52		<input type="checkbox"/> \$972.06		<input type="checkbox"/> \$1334.16
UnitedHealthcare (UHC) EPO		<input type="checkbox"/> \$485.52		<input type="checkbox"/> \$972.06		<input type="checkbox"/> \$1334.16
Arizona Foundation (AZF) PPO		<input type="checkbox"/> \$757.86		<input type="checkbox"/> \$1505.52		<input type="checkbox"/> \$2034.90
UnitedHealthcare (UHC) PPO		<input type="checkbox"/> \$757.86		<input type="checkbox"/> \$1505.52		<input type="checkbox"/> \$2034.90

All Other Counties

RAN+AMN (HMA) EPO		<input type="checkbox"/> \$485.52		<input type="checkbox"/> \$972.06		<input type="checkbox"/> \$1334.16
Arizona Foundation (AZF) PPO		<input type="checkbox"/> \$757.86		<input type="checkbox"/> \$1505.52		<input type="checkbox"/> \$2034.90

OUT-OF-STATE

Beech Street PPO		<input type="checkbox"/> \$823.14		<input type="checkbox"/> \$1625.88		<input type="checkbox"/> \$2213.40
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DENTAL PLANS (Monthly Cost Listed)

I DECLINE DENTAL COVERAGE

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$10.15		<input type="checkbox"/> \$19.29		<input type="checkbox"/> \$28.25
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$33.63		<input type="checkbox"/> \$75.49		<input type="checkbox"/> \$127.79

VISION PLAN (Monthly Cost Listed)

I DECLINE VISION COVERAGE

SELECT A PLAN	CODE	Tier 1	CODE	Tier 3
AVESIS VISION COVERAGE		<input type="checkbox"/> \$6.47		<input type="checkbox"/> \$17.52

Revised 03/25/09

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. <small>(USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)</small>	DATE OF BIRTH (MM/DD/YY)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED	ADD OR DELETE	INDICATE PLAN TYPE MEDICAL(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			<input type="checkbox"/> S <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> 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

The new American Recovery and Reinvestment Act of 2009, which the President signed into law on February 17, 2009, includes a 65 percent reduction on the cost of COBRA premiums for up to 9 months.

I DECLINE COBRA COVERAGE AND PREMIUM ASSISTANCE *

**By declining/waiving my right to COBRA coverage, I understand that I will not be permitted to select COBRA coverage in the future.*

I AM CURRENTLY ENROLLED IN COBRA AND DECLINE PREMIUM ASSISTANCE

FOR AGENCY USE ONLY - DO NOT WRITE IN THE SHADED AREAS

INVOLUNTARY TERMINATION DATE	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE
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MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.		SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> 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		

To qualify for premium assistance, you must check 'Yes' for all statements.

- | | |
|--|--|
| 1. The loss of employment was due to an involuntary termination. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. The loss of employment occurred between September 1, 2008 and December 31, 2009. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Individuals listed on this enrollment form are NOT eligible for other group health plan coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Individuals listed on this enrollment form are NOT eligible for Medicare. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. The member identified on this enrollment form has reviewed the included notification in its entirety. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MEDICAL PLANS (Monthly Cost)

If you and your dependents were enrolled in a medical plan on your termination date, you **MUST** continue with medical coverage in order to be eligible for the premium assistance on any plan. If you and your dependents were not enrolled in a medical plan on your termination date, you **MAY NOT** elect medical coverage, but you are eligible for premium assistance on vision and/or dental plans.

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		<input type="checkbox"/> \$169.93		<input type="checkbox"/> \$340.22		<input type="checkbox"/> \$466.96
UnitedHealthcare (UHC) EPO		<input type="checkbox"/> \$169.93		<input type="checkbox"/> \$340.22		<input type="checkbox"/> \$466.96
Arizona Foundation (AZF) PPO		<input type="checkbox"/> \$265.25		<input type="checkbox"/> \$526.93		<input type="checkbox"/> \$712.22
UnitedHealthcare (UHC) PPO		<input type="checkbox"/> \$265.25		<input type="checkbox"/> \$526.93		<input type="checkbox"/> \$712.22
All Other Counties						
RAN+AMN (HMA) EPO		<input type="checkbox"/> \$169.93		<input type="checkbox"/> \$340.22		<input type="checkbox"/> \$466.96
Arizona Foundation (AZF) PPO		<input type="checkbox"/> \$265.25		<input type="checkbox"/> \$526.93		<input type="checkbox"/> \$712.22
OUT-OF-STATE						
Beech Street PPO		<input type="checkbox"/> \$288.10		<input type="checkbox"/> \$569.06		<input type="checkbox"/> \$774.69

DENTAL PLANS (Monthly Cost)

I DECLINE DENTAL COVERAGE

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$3.56		<input type="checkbox"/> \$6.75		<input type="checkbox"/> \$9.89
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$11.77		<input type="checkbox"/> \$26.42		<input type="checkbox"/> \$44.73

VISION PLAN (Monthly Cost)

I DECLINE VISION COVERAGE

SELECT A PLAN	CODE	Tier 1	CODE	Not Applicable	CODE	Tier 3
AVESIS VISION COVERAGE		<input type="checkbox"/> \$2.26				<input type="checkbox"/> \$6.13

Effective January 1, 2009, Social Security numbers (SSN) will be required for primary members and all enrolled dependents.

The SSN is used as the basis for the Medicare health insurance claim number (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 benefits purposes.

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

LAST NAME, FIRST NAME, M.I. <small>(USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)</small>	DATE OF BIRTH (MM/DD/YY)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED	ADD OR DELETE	INDICATE PLAN TYPE MEDICAL(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			<table border="1" style="width: 100%; border-collapse: collapse; font-size: 8pt;"> <tr> <td><input type="checkbox"/> S - Spouse</td> <td><input type="checkbox"/> C - Child</td> </tr> <tr> <td><input type="checkbox"/> D - Domestic Partner</td> <td></td> </tr> <tr> <td><input type="checkbox"/> G - Guardian</td> <td></td> </tr> <tr> <td><input type="checkbox"/> P - Placed for adoption</td> <td></td> </tr> <tr> <td><input type="checkbox"/> T - Stepchild</td> <td></td> </tr> </table>	<input type="checkbox"/> S - Spouse	<input type="checkbox"/> C - Child	<input type="checkbox"/> D - Domestic Partner		<input type="checkbox"/> G - Guardian		<input type="checkbox"/> P - Placed for adoption		<input type="checkbox"/> T - Stepchild						
<input type="checkbox"/> S - Spouse	<input type="checkbox"/> C - Child																	
<input type="checkbox"/> D - Domestic Partner																		
<input type="checkbox"/> G - Guardian																		
<input type="checkbox"/> P - Placed for adoption																		
<input type="checkbox"/> T - Stepchild																		
Spouse or Domestic Partner			<input type="checkbox"/> S <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V										
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V										
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V										
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V										
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V										
			<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V										

I affirm that I am eligible for COBRA and premium assistance due to an involuntarily termination occurring between September 1, 2008 and December 31, 2009. I am not eligible for any other group health plan or Medicare. I have not previously waived my right to the premium assistance offered by the State of AZ or any other employer. 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, monetary penalties, 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

For additional COBRA help or to view pertinent frequently asked questions please visit:
www.benefitoptions.az.gov/cobrafaq

Revised 3/20/2009

PARTICIPANT NOTIFICATION

Use this form to notify the Benefit Services Division that you are eligible for other group health plan coverage or Medicare and therefore not eligible for premium assistance under ARRA.

PERSONAL INFORMATION

Participant full name and mailing address	Telephone Number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION

(INDIVIDUAL(S) LISTED BELOW IS/ARE NOW ELIGIBLE FOR OTHER GROUP HEALTH PLAN COVERAGE OR MEDICARE)

LAST NAME, FIRST NAME, M.I.	MEDICARE	OTHER GROUP HEALTH PLAN	DATE OF ELIGIBILITY	APPLICABLE COBRA ENROLLMENT DECISION
LIST FULL NAME (INCLUDE DEPENDENTS)	CHECK BOX	CHECK BOX	LIST DATE	CIRCLE ONE ELECTION
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES

IMPORTANT

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the premium assistance received after eligibility is lost.

Signature _____ Date _____

Type or print name _____

Please return this form to: **ADOA Benefit Services Division**
100 North 15th Avenue, Suite 103
Phoenix, Arizona 85007

Or fax this return form to: **(602) 542-4744**
Attention: Samantha Roberts