ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2019 BENEFIT OPTIONS - COBRA ENROLLMENT

Section A: Applicant Information

APPLICANT LAST NAME			APPLICANT FIRST NAME		APPLICANT M.I.
APPLICANT EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED	❑ NEW HIRE
STREET		CITY	ZIP	COUNTY	❑ RETURN-TO-WORK RETIREE
HOME PHONE	CELL PHONE		EMAIL		
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	EMPLOYEE ID NUMBER (EIN)	EMPLOYEE SOCIAL SECURITY NUMBER (REQUIRED)		

Section B: Reasons For Enrollment

B.1: SELECT REASON(S) FOR ENROLLMENT		B.2: QUALIFIED LIFE EVENT*	
❑ Open Enrollment	❑ Adding Dependent(s)	DATE OF EVENT: ____/____/____	❑ Dependent Eligibility Status Change
❑ New Enrollment	❑ Dropping Dependents(s)	❑ Marriage	❑ Death of Spouse/Dependent
❑ Qualified Life Event* (*FILL OUT SECTION B.2*)	❑ Terminate Coverage	❑ Birth/Adoption	❑ Gain/Loss of Other Coverage
	❑ Address Change	❑ Divorce/Legal Separation	❑ Moved Out of Plan's Service Area

Section C: Dependent Information

If adding dependents <u>not previously covered</u>: Submit this form AND the required supporting documentation, as listed on benefitoptions.az.gov under the Employee tab, to benefitsissues@azdoa.gov. For more than three dependents, continue to list information on a separate piece of paper.

Social Security Numbers: By federal law, you are required to provide a Social Security Number (SSN) for <u>all</u> dependents enrolled in our plans.
SSNs are needed to prepare IRS Form 1095-C under the Affordable Care Act (ACA). If you do not provide accurate SSNs, you may have an IRS penalty.

1	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)				CHECK ONE: ❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	❑ FEMALE ❑ MALE	DISABLED? ❑ YES ❑ NO	
	RELATIONSHIP (CHECK ONE) ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ GUARDIAN ❑ PLACED FOR ADOPTION		SELECT PLAN(S) ❑ MEDICAL ❑ DENTAL ❑ VISION		
2	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)				CHECK ONE: ❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	❑ FEMALE ❑ MALE	DISABLED? ❑ YES ❑ NO	
	RELATIONSHIP (CHECK ONE) ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ GUARDIAN ❑ PLACED FOR ADOPTION		SELECT PLAN(S) ❑ MEDICAL ❑ DENTAL ❑ VISION		
3	LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)				CHECK ONE: ❑ ADD ❑ REMOVE
	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	❑ FEMALE ❑ MALE	DISABLED? ❑ YES ❑ NO	
	RELATIONSHIP (CHECK ONE) ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ GUARDIAN ❑ PLACED FOR ADOPTION		SELECT PLAN(S) ❑ MEDICAL ❑ DENTAL ❑ VISION		

Section D: Enrollment Instructions

NOTICE

- *The coverage you elect must be <u>the exact same coverage</u> that you had immediately before your Qualified Life Event (QLE).
- If you do not select ENROLL or DECLINE for each coverage: medical, dental, and vision, <u>the coverage will be DECLINED automatically</u>.

Section E: Health Plan – COBRA Premiums Per Month

PLAN (CHECK ONE)	CARRIER	PLAN (CHECK ONE)			
		PPO - NAU - BCBS only	EPO - State	PPO - State	HDHP with HSA - State
❑ ENROLL ❑ DECLINE	❑ AETNA - State ❑ BCBSAZ - NAU ❑ BCBSAZ - State ❑ CIGNA** - State ❑ UHC - State	❑ $746.23 - EMPLOYEE ONLY ❑ $1,567.09 - EMPLOYEE + SPOUSE ❑ $1,119.35- EMPLOYEE + 1 CHILD ❑ $2,014.82 - FAMILY	❑ $637.54 - EMPLOYEE ONLY ❑ $1,352.40 - EMPLOYEE + SPOUSE ❑ $905.85 - EMPLOYEE + 1 CHILD ❑ $1,586.39 - FAMILY	❑ $718.86 - EMPLOYEE ONLY ❑ $1,518.25 - EMPLOYEE + SPOUSE ❑ $1,016.83 - EMPLOYEE + 1 CHILD ❑ $1,772.65 - FAMILY **Cigna not available for PPO.*	❑ $422.38 - EMPLOYEE ONLY ❑ $896.23 - EMPLOYEE + SPOUSE ❑ $599.08 - EMPLOYEE + 1 CHILD ❑ $1,048.06 - FAMILY

ADOA USE ONLY **COBRA EFFECTIVE DATE:** _____/_____/_____ **COBRA LENGTH:** _____

Section F: Dental Plans – Premiums Per Month

DENTAL PLAN (CHECK ONE)	PROVIDER (CHECK ONE)	
	PPO – DELTA DENTAL	DHMO – CIGNA DENTAL***
❑ ENROLL ❑ DECLINE	❑ $36.66 - EMPLOYEE ❑ $77.14 - EMPLOYEE + SPOUSE ❑ $61.69 - EMPLOYEE + 1 CHILD ❑ $120.63 - EMPLOYEE + FAMILY	❑ $8.69 - EMPLOYEE ❑ $17.38 - EMPLOYEE + SPOUSE ❑ $16.92 - EMPLOYEE + 1 CHILD ❑ $26.05 - EMPLOYEE + FAMILY ***Coverage not available in AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.

Section G: Vision Plan – Premiums Per Month

VISION PLAN	COVERAGE LEVEL (CHECK ONE)
	AVESIS ADVANTAGE PROGRAM
❑ ENROLL ❑ DECLINE	❑ $4.07 - EMPLOYEE ❑ $13.02 - EMPLOYEE + SPOUSE ❑ $13.20 - EMPLOYEE + 1 CHILD ❑ $16.42 - EMPLOYEE + FAMILY

Section H.1: Payment – NAU BCBSAZ PPO ONLY

COBRA continuation coverage for the NAU BCBSAZ PPO is administered by NAU Human Resources.
COBRA continuation coverage for the State medical plans and all the dental and vision plans is administered separately by ADOA – Benefit Services Division.

- If you enroll in the NAU BCBSAZ PPO you will be sent an invoice from our third party administrator ASI after your enrollment form has been received.
- If you elect to continue coverage for one of the State medical plans or the dental and\or vision plan there are different administrative rules and they are defined below.

Section H.2: First Payment – State Plans Only

- If you elect continuation coverage, you do not need to send payment with the Enrollment Form.
- **Your first payment is due (i.e., must be postmarked) no later than 45 days after the date your Enrollment Form was postmarked (or faxed, or scanned) and sent to ADOA – Benefit Services Division.**
- Keep in mind that your Enrollment Form will not be processed, and your COBRA coverage will not become effective, until payment is made in full.
- Further, if you fail to make your first payment within the 45 days allotted, you will lose all continuation coverage rights under the Plan.
- If payment is made on time (as indicated above), COBRA continuation coverage will begin the day after your job-based coverage ended.
- You are responsible for making sure that the amount of your first payment is correct.
- You may contact ADOA – Benefit Services to confirm the correct amount of your first payment.

INITIAL HERE: _____ INITIAL REQUIRED

Section H.3: Monthly Payment Requirements – State Plans Only

- After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments thereafter.
- The amount due per month for each qualified beneficiary will be sent to you in a billing statement from ADOA - HITF (Health Insurance Trust Fund).
- If you make a full payment on or before the due date, your continuation coverage under the Plan will continue for another month without a break.
- Billing statements are mailed as a courtesy. If you do not receive a bill, you may call ADOA - Benefit Services Division for assistance.

NOTICE

IF THE BALANCE DUE IS NOT PAID IN FULL BY THE DUE DATE, YOUR COVERAGE(S) ARE SUBJECT TO TERMINATION, AT ANY TIME, WITHOUT NOTICE, FOR NON-PAYMENT OF PREMIUMS.

INITIAL HERE: _____ (INITIAL REQUIRED)

Section I: Extending COBRA Coverage – State Plans Only

- If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled, or if a second qualifying life event occurs.
- You must notify the ADOA - Benefit Services Division of a disability or a second qualifying life event immediately to extend the period of continuation coverage.
- Failure to provide notice to the ADOA - Benefit Services Division of a disability or second qualifying event may affect your right to extend the period of continuation coverage.
- Please contact ADOA - Benefit Services Division for additional information if you have experienced a qualifying life event.

Section J: Submitting Application & Payments – State Plans Only

K.1: Application	**MAIL: Arizona Department of Administration-HITF, 100 N. 15th Ave., Suite 302, Phoenix, AZ 85007**
K.2: Payments	**ONLINE: benefitoptions.az.gov under COBRA Tab** **MAIL: At address above in Section K.1. Check/Money Order made out to: ADOA-HITF.**

Section K: Acknowledgement and Authorization – All Plans

I certify under penalty of perjury that the information provided in this application for health benefits, including Social Security numbers (SSN), addresses, spouse and/or dependent child(ren) information is true and accurate. I understand that providing false information may subject me to a denial of benefits and prosecution pursuant to A.R.S. §13-2310, 13-2311, 13-2407, 13-2702 and other applicable provisions of the law. I acknowledge I have received the Summary of Benefits and Coverage documents as part of the Affordable Care Act (ACA) electronically via benefitoptions.az.gov. I authorize the release of this information to my former employer, the Arizona Department of Administration (ADOA) and insurance carriers.
I hereby acknowledge if I fail to pay premiums as required, my benefits may be cancelled and I will be responsible for any paid claims.

APPLICANT NAME (PRINT CLEARLY) _____ **DATE** _____

APPLICANT SIGNATURE _____ ***(ELECTRONIC SIGNATURES NOT ACCEPTED)***

ARIZONA DEPARTMENT OF ADMINISTRATION-BENEFIT SERVICES DIVISION, 100 N. 15TH AVE, STE 302, PHOENIX, AZ 85007
FAX: 602-542-4744 | BENEFITSISSUES@AZDOA.GOV | PH: 602-542-5008 | TOLL-FREE: 1-800-304-3687 | BENEFITOPTIONS.AZ.GOV