

**Section 1: Applicant Information**

|                                    |                                   |                          |  |   |                |
|------------------------------------|-----------------------------------|--------------------------|--|---|----------------|
| APPLICANT LAST NAME                |                                   |                          | APPLICANT FIRST NAME   |   | APPLICANT M.I. |
| APPLICANT EMPLOYEE ID NUMBER (EIN) | SOCIAL SECURITY NUMBER (REQUIRED) | BIRTH DATE               | <input type="checkbox"/> FEMALE<br><input type="checkbox"/> MALE | <input type="checkbox"/> SINGLE<br><input type="checkbox"/> MARRIED |                |
| STREET                             |                                   | CITY                     | ZIP  | COUNTY  |                |
| HOME PHONE                         |                                   | CELL PHONE               | EMAIL  |   |                |
| EMPLOYEE LAST NAME                 | EMPLOYEE FIRST NAME               | EMPLOYEE ID NUMBER (EIN) | EMPLOYEE SOCIAL SECURITY NUMBER (REQUIRED)                       |   |                |

**Section 2: Reasons For Enrollment**

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 2a: SELECT REASON(S) FOR ENROLLMENT                                     |   | 2b: QUALIFIED LIFE EVENT* (See enrollment instructions in Section 4.) |  |  |  |
| <input type="checkbox"/> New Enrollment                                 | <input type="checkbox"/> Adding Dependent(s)    | DATE OF EVENT: ___/___/___  | <input type="checkbox"/> Dependent Eligibility Status Change |  |  |
| <input type="checkbox"/> Qualified Life Event*<br>(FILL OUT SECTION 2b) | <input type="checkbox"/> Dropping Dependents(s) | <input type="checkbox"/> Marriage                                     | <input type="checkbox"/> Death of Spouse/Dependent           |  |  |
|   | <input type="checkbox"/> Terminate Coverage     | <input type="checkbox"/> Birth/Adoption                               | <input type="checkbox"/> Gain/Loss of Other Coverage         |  |  |
|   | <input type="checkbox"/> Address Change         | <input type="checkbox"/> Divorce/Legal Separation                     | <input type="checkbox"/> Moved Out of Plan Service Area      |  |  |

**Section 3: Dependent Information**

**IF ADDING DEPENDENTS NOT PREVIOUSLY COVERED** - Submit this form and required supporting documents, as listed on [benefitoptions.az.gov](http://benefitoptions.az.gov) under the Employee tab, to [benefitsissues@azdoa.gov](mailto:benefitsissues@azdoa.gov). For more than three dependents, continue to list information on a separate piece of paper. **SOCIAL SECURITY NUMBERS (SSN):** ADOA requires SSNs for all enrolled dependents in order to prepare IRS Form 1095-c under the Affordable Care Act (ACA). Failure to provide valid SSNs may result in a tax penalty.

|   |   |            |  |   |   |
|---|---|------------|--|---|---|
| 1 | LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)   |            |  |   | CHECK ONE:<br><input type="checkbox"/> ADD<br><input type="checkbox"/> REMOVE |
|   | SOCIAL SECURITY NUMBER (REQUIRED)   | BIRTH DATE | <input type="checkbox"/> FEMALE<br><input type="checkbox"/> MALE   | DISABLED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
|   | RELATIONSHIP (CHECK ONE)<br><input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> GUARDIAN <input type="checkbox"/> PLACED FOR ADOPTION |            | SELECT PLAN(S)<br><input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION |   |   |
| 2 | LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)   |            |  |   | CHECK ONE:<br><input type="checkbox"/> ADD<br><input type="checkbox"/> REMOVE |
|   | SOCIAL SECURITY NUMBER (REQUIRED)   | BIRTH DATE | <input type="checkbox"/> FEMALE<br><input type="checkbox"/> MALE   | DISABLED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
|   | RELATIONSHIP (CHECK ONE)<br><input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> GUARDIAN <input type="checkbox"/> PLACED FOR ADOPTION |            | SELECT PLAN(S)<br><input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION |   |   |
| 3 | LAST NAME, FIRST NAME, M.I. (AS IT APPEARS ON SOCIAL SECURITY CARD)   |            |  |   | CHECK ONE:<br><input type="checkbox"/> ADD<br><input type="checkbox"/> REMOVE |
|   | SOCIAL SECURITY NUMBER (REQUIRED)   | BIRTH DATE | <input type="checkbox"/> FEMALE<br><input type="checkbox"/> MALE   | DISABLED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
|   | RELATIONSHIP (CHECK ONE)<br><input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> GUARDIAN <input type="checkbox"/> PLACED FOR ADOPTION |            | SELECT PLAN(S)<br><input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION |   |   |

**Section 4: Enrollment Instructions**



- \*The coverage you elect (medical/dental/vision) must be **the exact same coverage and carrier** 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, **the coverage will be DECLINED automatically.**

**Section 5: Health Plan – COBRA Premiums Per Month**

|  |  |  |   |   |
|--|--|--|---|---|
| ENROLL/DECLINE (CHECK ONE)<br><input type="checkbox"/> ENROLL <input type="checkbox"/> DECLINE   | CARRIER (CHECK ONE) NAU Plans: <input type="checkbox"/> One Carrier Only - Blue Cross Blue Shield AZ (BCBSAZ)<br>State Plans: <input type="checkbox"/> Aetna** <input type="checkbox"/> Blue Cross Blue Shield AZ (BCBSAZ) <input type="checkbox"/> CIGNA*** <input type="checkbox"/> UnitedHealthcare (UHC) |  |   |   |
| PLAN (CHECK ONE)   |  |  |   |   |
| NAU - PPO   BCBSAZ   | NAU - HDHP with HSA   BCBSAZ   | STATE – EPO   Choose Carrier Above   | STATE - PPO   Choose Carrier Above  | STATE - HDHP with HSA**   |
| <input type="checkbox"/> \$783.54 - EMPLOYEE ONLY<br><input type="checkbox"/> \$1,645.44 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$1,175.32 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$2,115.56 - FAMILY | <input type="checkbox"/> \$658.78 - EMPLOYEE ONLY<br><input type="checkbox"/> \$1,383.45 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$988.18 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$1,778.70 - FAMILY   | <input type="checkbox"/> \$637.54 - EMPLOYEE ONLY<br><input type="checkbox"/> \$1,352.40 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$905.85 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$1,586.39 - FAMILY | <input type="checkbox"/> \$718.86 - EMPLOYEE ONLY<br><input type="checkbox"/> \$1,519.25 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$1,016.83 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$1,772.65 - FAMILY<br><i>***Cigna not available for PPO</i> | <input type="checkbox"/> \$422.38 - EMPLOYEE ONLY<br><input type="checkbox"/> \$896.23 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$599.08 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$1,048.06 - FAMILY<br><i>**Aetna Only for State HDHP with HSA</i> |

ADOA USE ONLY

COBRA EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_

COBRA LENGTH: \_\_\_\_\_

| Section 6: Dental Plans – Premiums Per Month                        |   |   | Section 7: Vision Plan – Premiums Per Month                         |   |
|---|---|---|---|---|
| ENROLL/DECLINE (CHECK ONE)  | PROVIDER (CHECK ONE)  |   | ENROLL/DECLINE (CHECK ONE)  | COVERAGE LEVEL (CHECK ONE)  |
|   | PPO – DELTA DENTAL  | DHMO – CIGNA DENTAL***  |   | AVESIS ADVANTAGE PROGRAM  |
| <input type="checkbox"/> ENROLL<br><input type="checkbox"/> DECLINE | <input type="checkbox"/> \$36.66 - EMPLOYEE<br><input type="checkbox"/> \$77.14 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$61.69 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$120.63 - EMPLOYEE + FAMILY | <input type="checkbox"/> \$8.69 - EMPLOYEE<br><input type="checkbox"/> \$17.38 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$16.92 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$26.05 - EMPLOYEE + FAMILY<br>***Coverage not available in AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY. | <input type="checkbox"/> ENROLL<br><input type="checkbox"/> DECLINE | <input type="checkbox"/> \$4.07 - EMPLOYEE<br><input type="checkbox"/> \$13.20 - EMPLOYEE + SPOUSE<br><input type="checkbox"/> \$13.02 - EMPLOYEE + 1 CHILD<br><input type="checkbox"/> \$16.42 - EMPLOYEE + FAMILY |

**Section 8a: Payment – NAU Plans: PPO and HDHP with HSA ONLY**

COBRA continuation coverage for the NAU Plans: PPO and HDHP with HSA, 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 elect to continue coverage in an NAU Plan 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 8b: 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 8c: 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 9: 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 10: Submitting Application & Payments – State Plans Only**

|                         |  |
|-------------------------|--|
| <b>10a: Application</b> | MAIL: Arizona Department of Administration-HITF, 100 N. 15th Ave., Suite 302, Phoenix, AZ 85007  |
| <b>10b: Payments</b>    | ONLINE: <a href="http://benefitoptions.az.gov">benefitoptions.az.gov</a> under COBRA Tab<br>MAIL: To address above (in Section 10a). Check/Money Order made out to: ADOA-HITF. |

**Section 11: 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](http://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 (ADOA)-BENEFIT SERVICES DIVISION, 100 N. 15TH AVE, STE 302, PHOENIX, AZ 85007**  
**FAX: 602-542-4744 | BENEFITISSUES@AZDOA.GOV | PH: 602-542-5008 | TOLL-FREE: 1-800-304-3687 | BENEFITOPTIONS.AZ.GOV**