ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2024 COBRA ENROLLMENT NAU

Section 1: 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
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 (QLE)* (See enrollment instructions in Section 4.)	
❑ New Enrollment	❑ Adding Dependent(s)	DATE OF EVENT: _____	❑ Dependent Eligibility Status Change
❑ Qualified Life Event* ***(FILL OUT SECTION 2b)***	❑ Dropping Dependents(s)	❑ Marriage	❑ Death of Spouse/Dependent
	❑ Terminate Coverage	❑ Birth/Adoption	❑ Gain/Loss of Other Coverage
	❑ Address Change	❑ Divorce/Legal Separation	❑ 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/qle, to benefit@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: ❑ 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 4: Enrollment Instructions

NOTICE

- *The coverage you elect (medical/dental/vision) must be **the exact same coverage and carrier** that you had immediately before your 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) ❑ ENROLL ❑ DECLINE

CARRIER (CHECK ONE) NAU Plans: ❑ One Carrier Only - Blue Cross Blue Shield AZ (BCBSAZ)
State Plans: ❑ Blue Cross Blue Shield AZ (BCBSAZ) or ❑ UnitedHealthcare (UHC)

NAU - PPO | BCBSAZ	NAU - HDHP with HSA | BCBSAZ	STATE - Triple Choice Plan	STATE - HDHP with HSA
❑ $842.70 - EMPLOYEE ONLY	❑ $710.60 - EMPLOYEE ONLY	❑ $675.45 - EMPLOYEE ONLY	❑ $422.38 - EMPLOYEE ONLY
❑ $1,769.66 - EMPLOYEE + SPOUSE	❑ $1,492.53 - EMPLOYEE + SPOUSE	❑ $1,432.60 - EMPLOYEE + SPOUSE	❑ $896.23 - EMPLOYEE + SPOUSE
❑ $1,264.04 - EMPLOYEE + 1 CHILD	❑ $1,066.02 - EMPLOYEE + 1 CHILD	❑ $959.44 - EMPLOYEE + 1 CHILD	❑ $599.08 - EMPLOYEE + 1 CHILD
❑ $2,275.26 - FAMILY	❑ $1,919.00 - FAMILY	❑ $1,679.96 - FAMILY	❑ $1,048.06 - FAMILY

Section 6: Dental Plans - Premiums Per Month

ENROLL/ DECLINE (CHECK ONE)	PROVIDER (CHECK ONE)	
	STATE PPO - DELTA DENTAL	STATE DHMO - UHC Solstice DENTAL*
❑ ENROLL	❑ $36.66 - EMPLOYEE Only	❑ $8.69 - EMPLOYEE
❑ DECLINE	❑ $77.14 - EMPLOYEE + SPOUSE	❑ $17.38 - EMPLOYEE + SPOUSE
	❑ $61.69 - EMPLOYEE + 1 CHILD	❑ $16.92 - EMPLOYEE + 1 CHILD
	❑ $120.63 - FAMILY	❑ $26.05 - FAMILY

**Residents of these states/territories cannot enroll in the UHC Solstice DHMO: AK, AL, AR, DE, HI, IA, ID, LA, ME, MS, MT, ND, NE, NH, OK, RI, SD, VT, WV, WY, GU, USVI, and PR. Check provider availability on smilestateofaz.com, plan S800B.*

Section 7: Vision Plan - Premiums Per Month

ENROLL/ DECLINE (CHECK ONE)	COVERAGE LEVEL (CHECK ONE)
	STATE AVESIS ADVANTAGE
❑ ENROLL	❑ $3.79 - EMPLOYEE
❑ DECLINE	❑ $12.61 - EMPLOYEE + SPOUSE
	❑ $12.48 - EMPLOYEE + 1 CHILD
	❑ $15.71 - FAMILY

Section 8: Payments

NAU Plans: PPO and HDHP with HSA ONLY

PPO and HDHP with HSA, is administered by NAU Human Resources. 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.

STATE PLANS: MEDICAL (TRIPLE CHOICE AND HDHP WITH HSA), DENTAL AND VISION

State medical plans and all the dental and vision plans is administered separately by ADOA. 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 as defined below.

- 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, call ADOA at 602-542-5008.
- Pay online: benefitoptions.az.gov/cobra. Pay by mail: ADOA-HITF, 100 N. 15th Ave., Suite 302, Phoenix, AZ 85007. Check/Money Order made out to: ADOA-HITF.

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: _____ (Required)

Section 9: Extending COBRA Coverage & Medicare Information - All Plans

EXTENDING COBRA COVERAGE

- Qualified Life Event (QLE) - If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary a second QLE occurs. You must notify ADOA of a 2nd QLE within 31 days of the event to extend the period of continuation coverage. Failure to provide notice may affect your right to extend the period of continuation coverage. Please contact ADOA for additional information.
- Disability Extension - An 11-month extension of coverage may be available to your family if any of the qualified beneficiaries is determined to be disabled by the Social Security Administration. The disability must have existed sometime before the 60th day of your initial COBRA coverage period.

MEDICARE

- COBRA coverage ends when you or your covered dependent turns 65 and are eligible for Medicare.
- If you are over 65 and were actively employed, upon leaving State service, you are eligible to elect COBRA coverage.

Section 10: Submitting Application

APPLICATIONS SHOULD BE SUBMITTED TO NAU HUMAN RESOURCES:

MAIL: PO Box 4113, Flagstaff, AZ 86011 | EMAIL: NAUHRBENEFITS@NAU.EDU | FAX: 928-523-2220.

If you have questions, you can contact NAU Human Resources at NAUHRBENEFITS@NAU.EDU or call 928-523-2223.

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/resources. I authorize the release of this information to my former employer, 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.**

BENEFIT PLANS AND RATES LISTED EFFECTIVE JANUARY 1-DECEMBER 31, 2024.

DEPENDING ON INDIVIDUAL COBRA ELIGIBILITY, COVERAGE MAY END BEFORE DECEMBER 31, 2024.

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

APPLICANT SIGNATURE _____