

STATE OF ARIZONA/ARIZONA BOARD OF REGENTS
TRI-UNIVERSITY
 BENEFITS ELECTION CHANGE FORM
INSTRUCTIONS AND GUIDELINES

Return to:
 Human Resources
 888 N. Euclid Ave, Ste 114
 PO Box 210158
 Tucson, AZ 85721

FORM COMPLETION

- Keep a copy of completed and signed form, it is proof of your coverage/elections.

ELIGIBILITY GUIDELINES

Dependent Eligibility
 Eligible dependents are the employee's legally married spouse and each unmarried child (natural, adopted, foster, step-child or child placed by court order in employee's household) under age 19. Medical, dental, and dependent life eligibility continues to age 25 for full-time students. Step-children must reside in the employee's household to be eligible dependents. A disabled dependent child may continue on the plan with verification the child has a medically qualifying permanent disability that occurred prior to his or her 19th birthday.

Qualified Life Event Changes
 Requests for coverage changes due to qualifying Life Event changes (e.g. marriage, birth/adoption, divorce) must be submitted within either 31 days of the date of the qualifying event OR during an annual open enrollment period.

MEDICAL, DENTAL AND VISION PLANS

- Select up to one plan (in appropriate region) AND level of coverage, or decline.
- ALL dependents (including spouse) to be covered MUST be listed in Section D for family medical, dental and/or vision plan coverage. (Use a second form to list more than six names.)
- Spouse/dependent gender, date(s) of birth, Medicare enrollment and dependent address information must be provided.
- If spouse/dependent's last name differs from that of employee, documentation of eligibility (e.g. marriage license, birth certificate) must be attached, unless already on file. Full-time student status documentation for new dependents between ages 19 and 25 is also required.

SHORT TERM DISABILITY (STD) PLANS

PROVIDER	STANDARD	UNUMPROVIDENT
COST	\$0.87 per \$100 of base salary	\$0.84 per \$100 of base salary
FORMULA TO FIGURE PAY PERIOD PREMIUM	Annual salary ÷ 24 pay dates X .0089	Annual salary ÷ 24 pay dates X .0084
MAXIMUM ANNUAL SALARY (FOR COMPUTATION PURPOSES)	\$60,000	OPTION A - \$55,714 OPTION B - \$111,430 OPTION C - \$148,571
MAXIMUM WEEKLY BENEFIT	\$769	OPTION A - \$750 OPTION B - \$1,500 OPTION C - \$2,000

Refer to Benefits Enrollment Guide and plan brochure information for additional information on benefits, restrictions, pre-existing condition clauses, and disclaimers relating to Short Term Disability programs.

SUPPLEMENTAL LIFE INSURANCE
 (may select more than one plan)

MONTHLY PREMIUM SCHEDULE (per \$1,000 of coverage)

AGE	STANDARD INSURANCE	AETNA
18-24	\$.10	\$.06
25-29	.10	.06
30-34	.12	.06
35-39	.14	.10
40-44	.24	.16
45-49	.32	.26
50-54	.52	.32
55-59	.74	.50
60-64	1.34	.76
65-69	1.34	1.14
Age 70+	2.12	Contact Human Resources for rate information.
MINIMUM COVERAGE	\$5,000	Approximately 1 x annual salary up to \$300,000 (refer to Aetna Coverage Table for exact amt.)
MAXIMUM COVERAGE	Lesser of \$300,000 or 3 x annual salary	Approximately 3 x annual salary up to \$300,000 (refer to Aetna Coverage Table for exact amt.)
DEPENDENT COVERAGE (options and monthly premium)	See enrollment form	Spouse \$5,000/Children \$5,000 \$ 0.66 (may only be elected with Aetna supplemental life coverage)

BENEFICIARY DESIGNATION

- Beneficiaries listed on this form will be designated for all basic/supplemental life, AD&D, and Short Term Disability insurance plans. A minimum of one primary beneficiary is required for initial enrollment; additional primary and/or contingent beneficiaries are optional. Check "EQUAL AMOUNTS TO ALL" unless specific dollar amounts or percentages to different beneficiaries is desired. To designate different beneficiaries for different plans, a separate beneficiary form (BE-2) must be attached. (Contact Human Resources office for additional forms). If no change is requested to previous/current beneficiary designation(s), note "no change" in section H.

ANNUAL OPEN ENROLLMENT INFORMATION

CHANGES THAT MAY BE MADE DURING AN ANNUAL OPEN ENROLLMENT PERIOD:

MEDICAL, DENTAL AND VISION INSURANCE

- enroll in medical, dental and/or vision coverage
- change to a different medical and/or dental plan
- cancel medical, dental and/or vision coverage
- add or delete eligible family members from current coverage

SHORT TERM DISABILITY (STD) INSURANCE

Election of Standard Short Term Disability may be subject to "late enrollment clause". Refer to plan brochure for details.

- enroll for coverage (in one plan only)
- cancel coverage
- cancel coverage in one STD plan and enroll in the other

STANDARD LIFE INSURANCE

- increase supplemental coverage (in increments of \$5,000, increases may not exceed \$20,000 in any plan year or maximum limits (not applicable to 2004 open enrollment)
- decrease supplemental coverage (in increments of \$5,000)
- increase or decrease dependent coverage
- cancel supplemental and/or dependent coverage
- mark "NO CHANGE"

AETNA LIFE INSURANCE

- enroll in Option A, Option B, or Option C
- increase from Option A to Option B, or from Option B to Option C
- decrease from Option C to Option B, or from Option B to Option A
- add or delete dependent coverage
- cancel coverage
- mark "no change" to keep existing coverage level

ACTIVELY AT WORK PROVISION:

Plan provisions require that an employee be performing the duties of his/her normal occupation in order for enrollment or increases in coverage to commence. If an employee is absent due to illness or injury, requested enrollment or increases in coverage do not commence until the employee returns to work.

DECLARATION FOR PRE-TAX BENEFITS

- I authorize my employer to reduce my salary by applicable pre-tax dollars or deduct from my paycheck the applicable after tax dollars for the insurance programs which I have elected on this benefits change/enrollment form.
- I understand that my pre-tax election made herein is irrevocable and can be changed only as of October 1, of each year, or declared open enrollment; or in the event of a Qualified Life Event change (marriage, divorce, death of a spouse or eligible dependent, or birth or adoption of a child, or a child placed by court order in the employee's household, change in the status of a dependent child, change in my spouse's employment) and that I must elect this change in writing within 31 days of the Qualified Life Event.
- I am aware that my pre-tax plan contributions are ineligible as deductions for income tax purposes.
- I verify that the information on this form is true and complete and agree that it is my obligation to keep this information up-to-date.
- I authorize release of information to my insurance carriers and employer.
- I understand that as a "new hire" or first time enrollee my elected insurance coverage commences on the date I return to work, if I am not "actively at work" on the effective date. The "actively at work" provision includes regular non-working days provided I worked the preceding scheduled work day.
- I understand that newly elected short term disability coverage and life increases commence on the date I return to work, if I am not "actively at work" on the effective date. The "actively at work" provision includes regular non-working days provided I worked the preceding scheduled work day.
- I understand that failure to adhere to the above declarations may jeopardize my insurance coverage.

NOTICE TO PROVIDERS

The contracts between the State of Arizona and its health care plans provide that this document constitutes a valid temporary membership card and proof of entitlement for all provider services. Failure by a provider to honor this temporary membership card may subject the health care plan to sanctions under its contract with the State.

THE INFORMATION PROVIDED ON THIS BE-U FORM IS PROVIDED SOLELY AS A GUIDE TO HELP EMPLOYEES MAKE IMPORTANT ENROLLMENT DECISIONS. IF THERE IS ANY DISCREPANCY BETWEEN THIS INFORMATION AND THE OFFICIAL DOCUMENTS, THE OFFICIAL DOCUMENTS WILL ALWAYS GOVERN. THE STATE OF ARIZONA RESERVES THE RIGHT TO CHANGE OR TERMINATE ANY OF ITS PLANS, IN WHOLE OR IN PART, AT ANY TIME.

Fill in all information beginning with section A.
Form needs to be signed and dated.

**STATE OF ARIZONA/ARIZONA BOARD OF REGENTS
UNIVERSITY OF ARIZONA**

**BENEFITS ELECTION
CHANGE FORM**

AGENCY CODE UA	AGENCY NAME UNIVERSITY OF ARIZONA	Date received: _____ By: _____	EFFECTIVE DATE
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FOR AGENCY USE ONLY-DO NOT WRITE ABOVE THIS LINE

A. EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.		<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED	EMPLOYEE IDENTIFICATION NUMBER: _____ 00 _____	
		<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE		
STREET ADDRESS		COUNTY OF RESIDENCE	DATE OF BIRTH (MM/DD/YY)	DATE OF EMPLOYMENT (MM/DD/YY)	
CITY, STATE, ZIP CODE		WORK PHONE NUMBER	HOME PHONE NUMBER	CURRENT ANNUAL SALARY	
SPOUSE'S NAME		SPOUSE SOCIAL SECURITY NUMBER		IS SPOUSE EMPLOYED <input type="checkbox"/> NO <input type="checkbox"/> STATE <input type="checkbox"/> OTHER	
SPOUSE'S INSURANCE CO. & POLICY NO., CO. ADDRESS & PHONE NO.				NAME OF SPOUSE'S EMPLOYER	
				SPOUSE'S INSURANCE COVERAGE <input type="checkbox"/> SPOUSE ONLY <input type="checkbox"/> SPOUSE & FAMILY	

B. MEDICAL PLANS (select level of coverage and up to one plan)

Monthly Rates Shown

COVERAGE LEVEL	SOUTHERN REGION	CENTRAL REGION	SOUTHEAST REGION	NORTHERN REGION	WESTERN REGION	OUTSIDE ARIZONA
<input type="checkbox"/> SINGLE <input type="checkbox"/> DECLINE <input type="checkbox"/> FAMILY <input type="checkbox"/> NO CHANGE	(Pima, Santa Cruz Counties)	(Maricopa, Gila, Pinal Counties)	(Graham, Greenlee, Cochise Counties)	(Yavapai, Coconino, Navajo, Apache)	(Mohave, La Paz, Yuma)	
RAN+AMN (HMA) EPO \$25.00 (Single) \$125.00 (Family)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Beech Street PPO <input type="checkbox"/> \$25.00 (Single) \$125.00 (Family)
Schaller Anderson (SA) EPO \$25.00 (Single) \$125.00 (Family)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
United Healthcare (UHC) EPO \$25.00 (Single) \$125.00 (Family)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AZ Foundation (AZF) PPO \$140.00(Single) \$390.00(Family)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
United Healthcare (UHC) PPO \$140.00 (Single) \$390.00(Family)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

C. DENTAL PLANS (select level of coverage and up to one plan)

Monthly Rates Shown

COVERAGE LEVEL <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE <input type="checkbox"/> NO CHANGE	PREPAID PLANS		PPO PLANS
	<input type="checkbox"/> EMPLOYERS DENTAL SVC. (EDS) Dentist Code: _____ \$4.02 (Single) \$18.16 (Family)		<input type="checkbox"/> DELTA DENTAL \$14.56 (Single) \$54.14 (Family) <input type="checkbox"/> METLIFE DENTAL \$12.90(Single) \$45.00(Family)
	<input type="checkbox"/> FORTIS DENTAL \$4.68 (Single) \$18.02 (Family)		
	<input type="checkbox"/> FORTIS DENTAL \$4.68 (Single) \$18.02 (Family)		

D. AVESIS VISION CARE (select one)

Monthly Rates Shown

SINGLE COVERAGE (\$6.34)
 FAMILY COVERAGE (\$17.18)
 DECLINE COVERAGE
 NO CHANGE

E. DEPENDENTS PLEASE LIST ALL ELIGIBLE INDIVIDUALS TO BE ENROLLED IN MEDICAL, DENTAL, AND/OR VISION PLANS

LAST NAME	FIRST NAME	M.I.	BIRTHDATE (MM/DD/YY)	DEPENDENT MEDICARE INFORMATION (If yes, Circle Part A or B)	DEPENDENT ADDRESS INFORMATION Is address different than employee? (If yes, enter information below*)	RELATIONSHIP CODE (If G, P, or T, is marked, please refer to reverse side of form for documentation requirements.)	FULL TIME STUDENT or DISABLED? (If Yes, provide documentation required.)	Add / Delete (A/D)
01 Employee								
02 Spouse			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes Part A Part B <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codes: S=Spouse, C=Child, G=Guardian, P=Placed for Adoption, T=Step child	<input type="checkbox"/> Yes <input type="checkbox"/> No	
03 Dependents			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes Part A Part B <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> Yes <input type="checkbox"/> No	
04 Dependents			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes Part A Part B <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> Yes <input type="checkbox"/> No	
05 Dependents			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes Part A Part B <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> Yes <input type="checkbox"/> No	
06 Dependents			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes Part A Part B <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Enter dependent address if different from employee. Note applicable dependent name if more than one.

