

QUALIFIED LIFE EVENT BENEFITS ENROLLMENT FORM

FORM COMPLETION INSTRUCTIONS

1. Complete section A and make appropriate selections for Sections B-G
2. If you have more dependents or beneficiaries than form space allows, please attach an additional page
3. Sign and date page three, and retain a signed copy.
4. Submit the completed, signed, original form and any required supporting documentation to attention: Benefits at

Human Resources – University Services Building
888 N. Euclid Avenue, Suite 114
P.O. Box 210158
Tucson, Arizona 85721
(520) 621-3662, Option 3 FAX: (520) 621-9098

Human Resources – Arizona Health Sciences Center
1501 N. Campbell Avenue, Room 2233
P.O. Box 245018
Tucson, Arizona 85724
(520) 626-2600 FAX: (520) 626-8081

NOTICE TO PROVIDERS

The contracts between the State of Arizona and its health care providers 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 provider to sanctions under its contract with the State.

DISCLAIMER

The information provided on this form is provided solely as a guide to help employees make important enrollment decisions. If there are any discrepancies between this information and official documents, official documents will always govern. The State of Arizona reserves the right to change or terminate any of its plans, in whole or part, at any time.

SECTION A: EMPLOYEE IDENTIFICATION INFORMATION

Last Name, First Name, M.I.		<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee ID Number: <u> 00 </u>
Street Address		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partnership	Birth Date __/__/____
City, State, Zip Code	Work Phone ()	Home Phone ()	Hire/Eligibility Date __/__/____
Date of Qualified Life Event __/__/____		Type Of Qualified Life Event	
FOR HR USE ONLY	DATE RECEIVED:	RECEIVED BY:	EFFECTIVE DATE:

SECTION B: DEPENDENT INFORMATION

1	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	List Address If Different Than Employee's:	
	Relationship	Birth Date __/__/____	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	List Address If Different Than Employee's:	
	Relationship	Birth Date __/__/____	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
3	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	List Address If Different Than Employee's:	
	Relationship	Birth Date __/__/____	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
4	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	List Address If Different Than Employee's:	
	Relationship	Birth Date __/__/____	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
5	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	List Address If Different Than Employee's:	
	Relationship	Birth Date __/__/____	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No

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SECTION C: MEDICAL INSURANCE

Select Provider Network (check one)	
<input type="checkbox"/> No Change to Medical Coverage <input type="checkbox"/> Decline Medical Coverage <input type="checkbox"/> RAN/AMN EPO <input type="checkbox"/> United Healthcare EPO <input type="checkbox"/> Arizona Foundation PPO <input type="checkbox"/> United Healthcare PPO <input type="checkbox"/> Beech Street (Outside AZ) PPO	
Select Region (check one)	
<input type="checkbox"/> Metro AZ (Maricopa, Gila, Pinal, and Santa Cruz counties) <input type="checkbox"/> Rural AZ (remaining counties) <input type="checkbox"/> Outside AZ	
Select Coverage Option (check one)	List Dependent Name(s) from Section B:
<input type="checkbox"/> Single (Self)	_____
<input type="checkbox"/> Self + (1) pre-tax dependent	_____
<input type="checkbox"/> Family: Self + pre-tax dependents	_____
<input type="checkbox"/> Self + (1) post-tax Domestic Partner	_____
<input type="checkbox"/> Self + (1) pre-tax Domestic Partner	_____
<input type="checkbox"/> Self + (1) post-tax dependent	_____
<input type="checkbox"/> Family: Self + Domestic Partner + (1) pre-tax dependent	_____
<input type="checkbox"/> Family: Self + Domestic Partner + pre-tax dependents	_____
<input type="checkbox"/> Family: Self + post-tax dependents	_____
<input type="checkbox"/> Family: Self + Domestic Partner + post-tax dependents	_____
<input type="checkbox"/> Family: Self + pre-tax dependents + post-tax dependent(s)	_____
<input type="checkbox"/> Family: Self + (1) pre-tax dependent + post-tax dependent(s)	_____

SECTION D: DENTAL INSURANCE

Select Provider Network (check one)	
<input type="checkbox"/> No Change to Dental Coverage <input type="checkbox"/> Decline Dental Coverage <input type="checkbox"/> Elect Delta Dental PPO <input type="checkbox"/> Elect Total Dental Administrators Pre-Paid (contact carrier to select Primary Dental Provider before using services)	
Select Coverage Option (check one)	List Dependent Name(s) from Section B:
<input type="checkbox"/> Single (Self)	_____
<input type="checkbox"/> Self + (1) pre-tax dependent	_____
<input type="checkbox"/> Family: Self + pre-tax dependents	_____
<input type="checkbox"/> Self + (1) post-tax Domestic Partner	_____
<input type="checkbox"/> Self + (1) pre-tax Domestic Partner	_____
<input type="checkbox"/> Self + (1) post-tax dependent	_____
<input type="checkbox"/> Family: Self + Domestic Partner + (1) pre-tax dependent	_____
<input type="checkbox"/> Family: Self + Domestic Partner + pre-tax dependents	_____
<input type="checkbox"/> Family: Self + post-tax dependents	_____
<input type="checkbox"/> Family: Self + Domestic Partner + post-tax dependents	_____
<input type="checkbox"/> Family: Self + pre-tax dependents + post-tax dependent(s)	_____
<input type="checkbox"/> Family: Self + (1) pre-tax dependent + post-tax dependent(s)	_____

SECTION E: VISION INSURANCE

Select Provider (check one)	List Dependent Name(s) from Section B:
<input type="checkbox"/> No Change to Avesis Advantage Vision Care Insurance	_____
<input type="checkbox"/> Decline Avesis Advantage Vision Care Insurance	_____
<input type="checkbox"/> Elect Avesis Advantage Vision Care Insurance	_____
Select Coverage Option (check one)	_____
<input type="checkbox"/> Single (Self)	_____
<input type="checkbox"/> Family: Self + pre-tax dependent(s)	_____
<input type="checkbox"/> Family: Self + post-tax dependent(s)	_____

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SECTION F: LIFE INSURANCE[†]

Basic Life Insurance: Employer paid \$15,000 policy is automatic. Please designate at least one beneficiary or trust.			
The Standard Supplemental Life Insurance (check one)		The Standard Dependent Life Insurance (check one)	
<input type="checkbox"/> No Change to Standard Life Insurance <input type="checkbox"/> Decline The Standard Supplemental Life Insurance <input type="checkbox"/> Elect a change (increase or decrease) in a multiple of \$5,000, up to 3x your annual salary OR \$300,000, whichever is less: \$ _____		<input type="checkbox"/> No Change to Standard Dependent Life Insurance <input type="checkbox"/> Decline The Standard Dependent Life Insurance Elect a change (increase or decrease) in coverage level: <input type="checkbox"/> \$2,000 (\$0.94/mo) <input type="checkbox"/> \$12,000 (\$5.64/mo) <input type="checkbox"/> \$4,000 (\$1.88/mo) <input type="checkbox"/> \$15,000 (\$7.05/mo) <input type="checkbox"/> \$6,000 (\$2.82/mo)	
Are You a Non-Smoker? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No			
The Standard Beneficiary Information (check primary or secondary for each designated beneficiary)			
<input type="checkbox"/> No Change to Standard Life Insurance Beneficiary designation.			
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Aetna Supplemental Life Insurance (check one)		Aetna Dependent Life Insurance (check one)	
<input type="checkbox"/> No Change to Aetna Life Insurance <input type="checkbox"/> Decline Aetna Supplemental Life <input type="checkbox"/> Elect Option A (1x Annual Salary) <input type="checkbox"/> Elect Option B (2x Annual Salary) <input type="checkbox"/> Elect Option C (3x Annual Salary) (maximum \$300,000)		<input type="checkbox"/> No Change to Aetna Dependent Life Insurance <input type="checkbox"/> Decline Aetna Dependent Life <input type="checkbox"/> \$5,000 Each Dependent (\$0.66/mo)	
Aetna Beneficiary Information (check primary or secondary for each designated beneficiary)			
<input type="checkbox"/> No Change to Aetna Life Insurance Beneficiary designation.			
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

SECTION G: SHORT-TERM DISABILITY INSURANCE[†] - Note: You may elect only one Short Term Disability plan:

The Standard Short Term Disability			
<input type="checkbox"/> No Change to Standard Short Term Disability insurance <input type="checkbox"/> Decline <input type="checkbox"/> Elect			
Unum Short Term Disability			
<input type="checkbox"/> No Change to Unum Short Term Disability Insurance <input type="checkbox"/> Decline Unum Short Term Disability Insurance Elect (maximum annual salary) plan: <input type="checkbox"/> Option A (\$55,714) <input type="checkbox"/> Option B (\$111,430) <input type="checkbox"/> Option C (\$148,571)			
Unum Accidental Death and Dismemberment Beneficiary Information (check and complete applicable fields)			
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date __/__/____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

[†] Plan provisions require that you are actively at work on the effective date of coverage.

DECLARATION FOR PRE-TAX BENEFITS

- I authorize my employer to reduce my salary by applicable pre-tax amounts for the benefits I have elected in this form.
- I understand that my medical, dental and vision elections can be changed only during the annual Open Enrollment period, or by writing within 31 days after a qualified life event.
- I am aware that my insurance plan contributions are ineligible as deductions for income tax purposes.
- I authorize the release of this information to my insurance carriers and employer.
- I hereby certify under penalty of perjury that the information I have provided in this form is true and correct. I acknowledge that providing false information may subject me to denial of employment benefits, disciplinary action and potential legal action. I further acknowledge that it is my obligation to keep this information up to date.

By my signature below, I authorize Human Resources to enter form information into the benefits enrollment system, affirm that it is my responsibility to review my confirmation statement and will immediately notify Human Resources of disparities.

Printed Name: _____ **Signature:** _____

Employee ID Number: ___ **00** ___ **Date:** _____ **Email address:** _____

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REQUIRED SUPPORTING DOCUMENTATION

All required documentation must be in or translated to English before submission to Human Resources.

	DOCUMENTATION REQUIRED	EFFECTIVE DATE OF COVERAGE
MARITAL STATUS		
Marriage	Copy of marriage certificate.	HR receives form(s) between 1 st and 15 th : Coverage begins on 16 th (1 st of following month by employee's advance request)
Establishment of Domestic Partnership	Signed domestic partner affidavit and evidence of financial interdependence; see details at http://www.benefitoptions.az.gov/	HR receives form(s) between 15 th 1 st and last day of the month: Coverage begins on 1 st of the following month
Legal annulment Legal separation Divorce Dissolution of Domestic Partnership	Copy of official signed and dated legal document	The date of the event
Death of Spouse or Domestic Partner	Copy of death certificate	The day after the date of death
CHANGE IN DEPENDENT CHILDREN		
Birth	Copy of birth certificate (official or unofficial) or official hospital record	The date of the event
Adoption Placement for adoption Guardianship	Copy of official signed and dated legal document	
Foster care	Copy of official signed and dated legal document	HR receives form(s) between 1 st and 15 th : Coverage begins on 16 th (1 st of following month by employee's advance request) HR receives form(s) between 15 th 1 st and last day of the month: Coverage begins on 1 st of the following month
Dependent child marries	Copy of marriage certificate	The day after the date of marriage
Dependent child age 19 thru 24 becomes full-time student	Employee signature on this form	HR receives form(s) between 1 st and 15 th : Coverage begins on 16 th HR receives form(s) between 15 th 1 st and last day of the month: Coverage begins on 1 st of the following month
Dependent no longer full-time student Full-time student reaches age 25	Employee signature on this form	Last day of month classes ended Coverage ends at 11:59 before 25 th birthday
Death of dependent child	Copy of death certificate	The day after the date of death
LOSS OR GAIN IN COVERAGE		
Employee loses/gains coverage through <ul style="list-style-type: none"> • Medicare • Spouse's/domestic partner's employer Spouse/domestic partner/dependent child(ren) loses/gains coverage	Copy of enrollment form, ID card, HIPAA certificate or letter from other plan sponsor on letterhead. Information must specify the coverage that is/was effective, including the effective date of loss or gain of coverage and names of all dependents covered (if applicable). If adding to UA plan and spouse or dependent has a different last name, also submit a copy of marriage license or birth certificate	HR receives form(s) between 1 st and 15 th : Coverage begins on 16 th (1 st of following month by employee's advance request) HR receives form(s) between 15 th 1 st and last day of the month: Coverage begins on 1 st of the following month

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<p>Employee, spouse or dependent moves into service area AND changes permanent residence address OR leaves service area for an anticipated period longer than 90 days AND changes permanent residence address</p>	<p>For change in residence for the employee, the employee must update address in Employee Link. Contact Human Resources regarding additional required documentation</p>	<p>The date of the change in permanent residence</p>
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