

**STATE OF ARIZONA
COBRA
ENROLLMENT/CHANGE 2007-2008**

NEW COBRA ENROLLMENT QUALIFIED LIFE EVENT ADDRESS CHANGE TERMINATION OF COBRA

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE REC'D	EFFECTIVE DATE
DURATION OF COBRA COVERAGE			
<input type="checkbox"/> 18 MONTHS <input type="checkbox"/> 29 MONTHS (only if disabled at the time of COBRA election) <input type="checkbox"/> 36 MONTHS			

A. IDENTIFICATION

COBRA PARTICIPANT (Last, First, Middle)	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE
STREET ADDRESS	CITY, STATE, ZIP CODE	COUNTY	DATE OF BIRTH
WORK PHONE NUMBER ()	HOME PHONE NUMBER ()	EMPLOYEE, IF OTHER THAN PARTICIPANT	
EMPLOYEE AGENCY ARIZONA STATE UNIVERSITY		EMPLOYEE ID #	

B. MEDICAL PLAN (Employee Monthly Costs Listed)

I DECLINE MEDICAL COVERAGE

CENTRAL REGION: MARICOPA, GILA, & PINAL COUNTIES

	CODE	PARTICIPANT	CODE	PARTICIPANT + 1	CODE	FAMILY	MAKE CHECK TO:
RAN+AMN EPO	01	<input type="checkbox"/> \$471.15	02	<input type="checkbox"/> \$930.74	03	<input type="checkbox"/> \$1259.84	FISERV HEALTH HARRINGTON
Schaller Anderson Healthcare EPO	01	<input type="checkbox"/> \$471.15	02	<input type="checkbox"/> \$930.74	03	<input type="checkbox"/> \$1259.84	FISERV HEALTH HARRINGTON
United Healthcare EPO	01	<input type="checkbox"/> \$471.15	02	<input type="checkbox"/> \$930.74	03	<input type="checkbox"/> \$1259.84	UNITED HEALTHCARE
Arizona Foundation PPO	01	<input type="checkbox"/> \$763.99	02	<input type="checkbox"/> \$1509.25	03	<input type="checkbox"/> \$2042.92	FISERV HEALTH HARRINGTON
United Healthcare PPO	01	<input type="checkbox"/> \$763.99	02	<input type="checkbox"/> \$1509.25	03	<input type="checkbox"/> \$2042.92	UNITED HEALTHCARE

SOUTHERN REGION: PIMA AND SANTA CRUZ COUNTIES

RAN+AMN EPO	01	<input type="checkbox"/> \$457.09	02	<input type="checkbox"/> \$902.99	03	<input type="checkbox"/> \$1222.29	FISERV HEALTH HARRINGTON
Schaller Anderson Healthcare EPO	01	<input type="checkbox"/> \$457.09	02	<input type="checkbox"/> \$902.99	03	<input type="checkbox"/> \$1222.29	FISERV HEALTH HARRINGTON
United Healthcare EPO	01	<input type="checkbox"/> \$457.09	02	<input type="checkbox"/> \$902.99	03	<input type="checkbox"/> \$1222.29	UNITED HEALTHCARE
Arizona Foundation PPO	01	<input type="checkbox"/> \$703.47	02	<input type="checkbox"/> \$1389.70	03	<input type="checkbox"/> \$1881.09	FISERV HEALTH HARRINGTON
United Healthcare PPO	01	<input type="checkbox"/> \$703.47	02	<input type="checkbox"/> \$1389.70	03	<input type="checkbox"/> \$1881.09	UNITED HEALTHCARE

NORTHERN REGION: YAVAPAI, COCONINO, NAVAJO, AND APACHE COUNTIES

RAN+AMN EPO	01	<input type="checkbox"/> \$623.51	02	<input type="checkbox"/> \$1231.74	03	<input type="checkbox"/> \$1667.28	FISERV HEALTH HARRINGTON
Schaller Anderson Healthcare EPO	01	<input type="checkbox"/> \$623.51	02	<input type="checkbox"/> \$1231.74	03	<input type="checkbox"/> \$1667.28	FISERV HEALTH HARRINGTON
Arizona Foundation PPO	01	<input type="checkbox"/> \$798.03	02	<input type="checkbox"/> \$1576.49	03	<input type="checkbox"/> \$2133.94	FISERV HEALTH HARRINGTON

RAN+AMN EPO	01	<input type="checkbox"/> \$623.51	02	<input type="checkbox"/> \$1231.74	03	<input type="checkbox"/> \$1667.28	FISERV HEALTH HARRINGTON
Schaller Anderson Healthcare EPO	01	<input type="checkbox"/> \$623.51	02	<input type="checkbox"/> \$1231.74	03	<input type="checkbox"/> \$1667.28	FISERV HEALTH HARRINGTON
Arizona Foundation PPO	01	<input type="checkbox"/> \$798.03	02	<input type="checkbox"/> \$1576.49	03	<input type="checkbox"/> \$2133.94	FISERV HEALTH HARRINGTON

WESTERN REGION: MOHAVE, LA PAZ, AND YUMA COUNTIES

RAN+AMN EPO	01	<input type="checkbox"/> \$623.51	02	<input type="checkbox"/> \$1231.74	03	<input type="checkbox"/> \$1667.28	FISERV HEALTH HARRINGTON
Schaller Anderson Healthcare EPO	01	<input type="checkbox"/> \$623.51	02	<input type="checkbox"/> \$1231.74	03	<input type="checkbox"/> \$1667.28	FISERV HEALTH HARRINGTON
Arizona Foundation PPO	01	<input type="checkbox"/> \$798.03	02	<input type="checkbox"/> \$1576.49	03	<input type="checkbox"/> \$2133.94	FISERV HEALTH HARRINGTON

OUT-OF-STATE

Beech Street PPO	01	<input type="checkbox"/> \$818.02	02	<input type="checkbox"/> \$1616.00	03	<input type="checkbox"/> \$2187.40	FISERV HEALTH HARRINGTON
------------------	----	-----------------------------------	----	------------------------------------	----	------------------------------------	--------------------------

Benefit Options
CHOICE. VALUE. HEALTH

**STATE OF ARIZONA
COBRA
ENROLLMENT/CHANGE 2007-2008 CONTINUED**

C. DENTAL PLAN (Monthly Costs Listed)		SINGLE COVERAGE		FAMILY COVERAGE		
<input type="checkbox"/> I DECLINE DENTAL COVERAGE		PLAN CODE		PLAN CODE		PAYABLE TO:
DELTA DENTAL PPO	IN ARIZONA AND OUT-OF-STATE	03	<input type="checkbox"/> \$35.07	04	<input type="checkbox"/> 112.24	DELTA
METLIFE DENTAL PPO	IN ARIZONA AND OUT-OF-STATE	07	<input type="checkbox"/> \$34.16	08	<input type="checkbox"/> 107.24	METLIFE
EMPLOYERS DENTAL SERVICES	IN ARIZONA ONLY	09	<input type="checkbox"/> \$10.40	10	<input type="checkbox"/> 30.25	EDS
ASSURANT BENEFITS	IN ARIZONA ONLY	01	<input type="checkbox"/> \$11.08	02	<input type="checkbox"/> 30.11	ASSURANT

D. VISION PLAN (Monthly Cost Listed)

I DECLINE VISION COVERAGE

Make check payable to: Avesis, for one year premium

AVESIS SINGLE COVERAGE \$6.47
Plan Code 05

AVESIS FAMILY COVERAGE \$17.52
Plan Code 06

E. DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, MI	DATE OF BIRTH	MEDICARE	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED Y OR N	ADD (A) OR DELETE (D)
		A=Medicare A B=Medicare B C=Medicare A & B D=Medicare unknown E=No Medicare	S=Spouse C=Child G=Guardian P=Placed for adoption T=Stepchild				
Employee		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E					
Spouse		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	<input type="checkbox"/> S	<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	<input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> T	<input type="checkbox"/> M <input type="checkbox"/> F			

USE AN ADDITIONAL FORM FOR MORE DEPENDENTS

G. MEMBER AUTHORIZATION AND SIGNATURE

I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information is correct and true. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to

ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In addition, I have read and understand the declarations.

SIGNATURE: _____ DATE: _____

**Return form to:
ASU Human Resources
Benefits Design & Management
P.O. Box 875612, Tempe, Arizona 85287-5612
or fax to 480-993-0007**