



# BENEFITS DECLARATION FOR CHANGE

This form must be submitted **within 31 days** of the Qualified Life Event

NAME \_\_\_\_\_

AFFILIATE # \_\_\_\_\_

<b>DEPENDENTS</b>	
<b>Add Spouse</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Loses eligibility for Medicare <input type="checkbox"/> Loses eligibility for AHCCCS <input type="checkbox"/> Loses coverage with own employer <input type="checkbox"/> Goes through Open Enrollment with own employer <input type="checkbox"/>	<b>Remove Spouse</b> <input type="checkbox"/> Legal annulment <input type="checkbox"/> Legal separation <input type="checkbox"/> Divorce <input type="checkbox"/> Becomes eligible for Medicare <input type="checkbox"/> Becomes eligible for AHCCCS <input type="checkbox"/> Gains coverage with own employer <input type="checkbox"/> Death of spouse <input type="checkbox"/>
<b>Add Child</b> <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Placement for adoption <input type="checkbox"/> Guardianship <input type="checkbox"/> Foster care <input type="checkbox"/> Qualified Medical Child Support Order <input type="checkbox"/> Becomes full-time student <input type="checkbox"/> Loses eligibility for Medicare <input type="checkbox"/> Loses eligibility for AHCCCS <input type="checkbox"/>	<b>Remove Child</b> <input type="checkbox"/> Marries <input type="checkbox"/> Reaches age 19 & is not a full-time student <input type="checkbox"/> Ceases to be a full-time student <input type="checkbox"/> Full-time student reaches age 25 <input type="checkbox"/> Loss of guardianship <input type="checkbox"/> Loss of foster care <input type="checkbox"/> Qualified Medical Child Support Order rescinded <input type="checkbox"/> Gains coverage with own employer <input type="checkbox"/> Death of child <input type="checkbox"/>
<b>EMPLOYEE</b>	<b>MISCELLANEOUS</b>
<input type="checkbox"/> Becomes Full-Time or Regular <input type="checkbox"/> Becomes Part-Time or Temporary <input type="checkbox"/> Goes on Un-Paid Leave <input type="checkbox"/> Returns from Un-Paid Leave <input type="checkbox"/> Loses coverage elsewhere <input type="checkbox"/> Gains coverage elsewhere <input type="checkbox"/>	<input type="checkbox"/> Cancel Short-Term Disability <input type="checkbox"/> Cancel Dependent Supplemental Life <input type="checkbox"/> Change Flexible Spending Account <input type="checkbox"/>

### DOCUMENTATION REQUIRED (AS APPLICABLE)

In English or with translation    Copies are acceptable

Documentation must include the event date or effective date for loss or gain of coverage.

- |   |                     |
|---|---------------------|
| ❖ Marriage license (for marriage or if spouse has different last name)  | ❖ Enrollment Form   |
| ❖ Birth certificate (for birth or if children have different last name) | ❖ Insurance ID card |
| ❖ Application for birth certificate or official hospital birth record   | ❖ HIPAA certificate |
| ❖ Annulment, separation or divorce decree                               | ❖ Death Certificate |
| ❖ Letter from Medicare, AHCCCS or other company plan sponsor            |                     |
| ❖ Any official, signed and dated documentation supporting request       |                     |

**THIS FORM MUST BE RECEIVED WITH 31 DAYS OF THE EVENT.**

**In the case of marriage or birth, DO NOT submit this form prior to the event.**

**Do not delay submitting this form while you wait for documentation (i.e. a marriage license from another state or country, the official birth certificate)**

DATE OF EVENT \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

For Human Resources Use Only		
Effective Date _____	Date Input _____	Input By _____

**FOR HUMAN RESOURCES USE ONLY**  
**DATE RECEIVED:**

**EFFECTIVE DATE:**

**A. EMPLOYEE IDENTIFICATION**

Employee LAST NAME, FIRST NAME, M. I.		ASU AFFILIATE #	
STREET ADDRESS			
CITY, STATE, ZIP CODE		WORK PHONE NUMBER (    )	HOME PHONE NUMBER (    )

**B. MEDICAL PLAN (monthly costs listed)**

**I DECLINE MEDICAL COVERAGE**

MARICOPA, GILA, & PINAL COUNTIES	SINGLE	EMPLOYEE + 1	FAMILY
EPOs: RAN+AMN	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
Schaller Anderson Healthcare	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
UnitedHealthcare	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
PPOs: Arizona Foundation	<input type="checkbox"/> \$140.00	<input type="checkbox"/> \$280.00	<input type="checkbox"/> \$390.00
UnitedHealthcare	<input type="checkbox"/> \$140.00	<input type="checkbox"/> \$280.00	<input type="checkbox"/> \$390.00
<b>PIMA &amp; SANTA CRUZ COUNTIES</b>			
EPOs: RAN+AMN	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
Schaller Anderson Healthcare	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
UnitedHealthcare	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
PPOs: Arizona Foundation	<input type="checkbox"/> \$140.00	<input type="checkbox"/> \$280.00	<input type="checkbox"/> \$390.00
UnitedHealthcare	<input type="checkbox"/> \$140.00	<input type="checkbox"/> \$280.00	<input type="checkbox"/> \$390.00
<b>YAVAPAI, COCONINO, NAVAJO &amp; APACHE COUNTIES</b>			
EPO: RAN+AMN	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
Schaller Anderson	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
PPO: Arizona Foundation	<input type="checkbox"/> \$140.00	<input type="checkbox"/> \$280.00	<input type="checkbox"/> \$390.00
<b>GRAHAM, GREENLEE &amp; COCHISE COUNTIES</b>			
EPO: RAN/AMN	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
Schaller Anderson	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
PPO: Arizona Foundation	<input type="checkbox"/> \$140.00	<input type="checkbox"/> \$280.00	<input type="checkbox"/> \$390.00
<b>MOHAVE, LA PAZ &amp; YUMA COUNTIES</b>			
EPO: RAN+AMN	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
Schaller Anderson	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00
PPO: Arizona Foundation	<input type="checkbox"/> \$140.00	<input type="checkbox"/> \$280.00	<input type="checkbox"/> \$390.00
<b>OUT OF STATE residents</b>			
PPO: Beech Street	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00

**FAX TO 480-993-0007**

<b>Employee LAST NAME, FIRST NAME, M.I.</b>		<b>AFFILIATE #</b>	
<b>C. DENTAL PLAN (monthly costs listed)</b>		<input type="checkbox"/> <b>I DECLINE DENTAL COVERAGE</b>	
		<b>SINGLE</b>	<b>FAMILY</b>
PPOs: DELTA DENTAL - IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$14.56	<input type="checkbox"/> \$54.14
METLIFE DENTAL - IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$12.90	<input type="checkbox"/> \$45.00
PRE-PAID: EMPLOYERS DENTAL SERVICES - IN ARIZONA ONLY		<input type="checkbox"/> \$4.02	<input type="checkbox"/> \$18.16
ASSURANT - IN ARIZONA ONLY		<input type="checkbox"/> \$4.68	<input type="checkbox"/> \$18.02
<b>D. VISION COVERAGE (monthly costs listed)</b>		<input type="checkbox"/> <b>I DECLINE VISION COVERAGE</b>	
AVESIS VISION PLAN		<input type="checkbox"/> \$6.34	<input type="checkbox"/> \$17.18
<b>E. DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans</b>			
	RELATION: S=SPOUSE C=CHILD G=GUARDIAN P=PLACED FOR ADOPTION T=STEPCHILD MEDICARE: A=MEDICARE A B= MEDICARE B C=MEDICARE A&B D= UNKNOWN E= NO MEDICARE		
Spouse Last Name, First  <i>If last name is different, submit copy of marriage license</i> Address, if different:	Date of Birth: _____  <input type="checkbox"/> Male  <input type="checkbox"/> Female	Is your spouse employed by: <input type="checkbox"/> ASU <input type="checkbox"/> State of Arizona, the University of Arizona, Northern Arizona University, or ABOR If so, neither you nor your spouse can be covered under both plans Relation Code _____ Medicare Code _____	<input type="checkbox"/> Add <input type="checkbox"/> Delete  <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent Last Name, First  <i>If last name is different, submit copy of birth certificate</i> Address, if different:	Date of Birth: _____  <input type="checkbox"/> Male <input type="checkbox"/> Female Full Time Student? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Male <input type="checkbox"/> Female Disabled? <input type="checkbox"/> Y <input type="checkbox"/> N	Relation Code _____ Medicare Code _____  <input type="checkbox"/> Add <input type="checkbox"/> Delete  <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent Last Name, First  <i>If last name is different, submit copy of birth certificate</i> Address, if different:	Date of Birth: _____  <input type="checkbox"/> Male <input type="checkbox"/> Female Full Time Student? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Male <input type="checkbox"/> Female Disabled? <input type="checkbox"/> Y <input type="checkbox"/> N	Relation Code _____ Medicare Code _____  <input type="checkbox"/> Add <input type="checkbox"/> Delete  <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent Last Name, First  <i>If last name is different, submit copy of birth certificate</i> Address, if different:	Date of Birth: _____  <input type="checkbox"/> Male <input type="checkbox"/> Female Full Time Student? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Male <input type="checkbox"/> Female Disabled? <input type="checkbox"/> Y <input type="checkbox"/> N	Relation Code _____ Medicare Code _____  <input type="checkbox"/> Add <input type="checkbox"/> Delete  <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent Last Name, First  <i>If last name is different, submit copy of birth certificate</i> Address, if different:	Date of Birth: _____  <input type="checkbox"/> Male <input type="checkbox"/> Female Full Time Student? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Male <input type="checkbox"/> Female Disabled? <input type="checkbox"/> Y <input type="checkbox"/> N	Relation Code _____ Medicare Code _____  <input type="checkbox"/> Add <input type="checkbox"/> Delete  <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<b>F. SHORT-TERM DISABILITY</b>			
<b>STANDARD SHORT-TERM DISABILITY</b>		<input type="checkbox"/> DECLINE	<input type="checkbox"/> ELECT
<b>UNUM PROVIDENT SHORT-TERM DISABILITY</b>		<input type="checkbox"/> DECLINE	<input type="checkbox"/> OPTION A <input type="checkbox"/> OPTION B <input type="checkbox"/> OPTION C

**FAX TO 480-993-0007**

<b>Employee LAST NAME, FIRST NAME, M.I.</b>	<b>AFFILIATE #</b>
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<b>G. PRIMARY BENEFICIARY</b>		
		<b>PRIMARY Percentage must = 100%</b>
#1 Beneficiary Last Name, First Name	Social Security Number (optional)	Date of Birth
Street, City, State, Zip Code		Phone No. (     )
Relationship		Payment %
#2 Beneficiary Last Name, First Name	Social Security Number (optional)	Date of Birth
Street, City, State, Zip Code		Phone No. (     )
Relationship		Payment %
<b>List additional Beneficiaries or Trust information on Supplemental Page</b>		

<b>H. CONTINGENT BENEFICIARY</b>		
		<b>CONTINGENT Percentage must = 100%</b>
#1 Beneficiary Last Name, First Name	Social Security Number (optional)	Date of Birth
Street, City, State, Zip Code		Phone No. (     )
Relationship		Payment %
#2 Beneficiary Last Name, First Name	Social Security Number (optional)	Date of Birth
Street, City, State, Zip Code		Phone No. (     )
Relationship		Payment %

<b>I. STANDARD EMPLOYEE SUPPLEMENTAL LIFE INSURANCE</b>	<b>STANDARD DEPENDENT SUPPLEMENTAL LIFE</b>
<input type="checkbox"/> <b>I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE</b> <input type="checkbox"/> I Elect Coverage in the Amount of \$ _____ <span style="margin-left: 200px;">In increments of \$5,000</span> <input type="checkbox"/> I am a Non-Smoker for the last 6 months (additional \$1,000 benefit)	<input type="checkbox"/> <b>I DECLINE DEPENDENT SUPPLEMENTAL COVERAGE</b> <input type="checkbox"/> I Elect Coverage in the Amount of: <input type="checkbox"/> \$2,000 \$0.94/month <input type="checkbox"/> \$12,000 \$5.64/month <input type="checkbox"/> \$4,000 \$1.88/month <input type="checkbox"/> \$15,000 \$7.06/month <input type="checkbox"/> \$6,000 \$2.82/month

<b>J. AETNA SUPPLEMENTAL LIFE INSURANCE</b>
<input type="checkbox"/> <b>I DECLINE AETNA SUPPLEMENTAL INSURANCE COVERAGE</b> <input type="checkbox"/> Option A (1 x annual salary) <input type="checkbox"/> Option B (2 x annual salary) <input type="checkbox"/> Option C (3 x annual salary)

<b>EMPLOYEE AUTHORIZATION AND SIGNATURE</b>
<p>I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information, is true and correct. 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 provision of the law.</p> <p><b>EMPLOYEE SIGNATURE</b> _____</p> <p><b>DATE</b> _____</p>

## Supplemental Page for **ADDITIONAL** Beneficiary and Dependent Information

Employee LAST NAME, FIRST NAME, M.I.		AFFILIATE #	
<b>ADDITIONAL BENEFICIARIES</b>			
Beneficiary Last Name, First Name		Social Security Number (Optional)	Date of Birth
Street, City, State, Zip Code		Phone No. ( )	
Relationship		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
Beneficiary Last Name, First Name		Social Security Number (Optional)	Date of Birth
Street, City, State, Zip Code		Phone No. ( )	
Relationship		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
Beneficiary Last Name, First Name		Social Security Number (optional)	Date of Birth
Street, City, State, Zip Code		Phone No. ( )	
Relationship		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
<b>TRUST OR LEGAL AGREEMENT</b>			
Name of Trust or Legal Agreement			
Street, City, State, Zip Where Filed			
Date of Trust			
<b>ADDITIONAL DEPENDENTS</b>			
Dependent Last Name, First  If last name is different, submit copy of birth certificate Address, if different:	Date of Birth: _____  Full Time Student? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Male  <input type="checkbox"/> Female  Disabled? <input type="checkbox"/> Y <input type="checkbox"/> N	Relation Code _____  Medicare Code _____  <input type="checkbox"/> Add or <input type="checkbox"/> Delete  <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent Last Name, First  If last name is different, submit copy of birth certificate Address, if different:	Date of Birth: _____  Full Time Student? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Male  <input type="checkbox"/> Female  Disabled? <input type="checkbox"/> Y <input type="checkbox"/> N	Relation Code _____  Medicare Code _____  <input type="checkbox"/> Add or <input type="checkbox"/> Delete  <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<b>EMPLOYEE AUTHORIZATION AND SIGNATURE</b>			
I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information is true and correct. 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 provision of the law.			
EMPLOYEE SIGNATURE _____		DATE _____	