



BENEFITS DECLARATION FOR CHANGE

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

NAME _____

AFFILIATE # _____

DEPENDENTS			
Add Spouse <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"/>	Remove Spouse <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"/>		
Add Child <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"/>	Remove Child <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 Qualified Medical Child Support Order rescinded 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"/>		
EMPLOYEE	MISCELLANEOUS		
<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. <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> ❖ Marriage license (for marriage or if spouse has different last name) ❖ Birth certificate (for birth or if children have different last name) ❖ Application for birth certificate or official hospital birth record ❖ Annulment, separation or divorce decree ❖ Letter from Medicare, AHCCCS or other company plan sponsor ❖ Any official, signed and dated documentation supporting request </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> ❖ Enrollment Form ❖ Insurance ID card ❖ HIPAA certificate ❖ Death Certificate </td> </tr> </table> <p style="text-align: center; color: red; font-weight: bold;"> 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) </p>		<ul style="list-style-type: none"> ❖ Marriage license (for marriage or if spouse has different last name) ❖ Birth certificate (for birth or if children have different last name) ❖ Application for birth certificate or official hospital birth record ❖ Annulment, separation or divorce decree ❖ Letter from Medicare, AHCCCS or other company plan sponsor ❖ Any official, signed and dated documentation supporting request 	<ul style="list-style-type: none"> ❖ Enrollment Form ❖ Insurance ID card ❖ HIPAA certificate ❖ Death Certificate
<ul style="list-style-type: none"> ❖ Marriage license (for marriage or if spouse has different last name) ❖ Birth certificate (for birth or if children have different last name) ❖ Application for birth certificate or official hospital birth record ❖ Annulment, separation or divorce decree ❖ Letter from Medicare, AHCCCS or other company plan sponsor ❖ Any official, signed and dated documentation supporting request 	<ul style="list-style-type: none"> ❖ Enrollment Form ❖ Insurance ID card ❖ HIPAA certificate ❖ Death Certificate 		

DATE OF EVENT _____

Coverage is effective the first of the pay period following the event date or as mandated by Internal Revenue Code Section 125.

SIGNATURE _____

DATE _____

For Human Resources Use Only

Effective Date _____

Date Input _____

Input By _____

FAX TO 480-993-0007

Revised: 7-2008

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
PIMA & SANTA CRUZ COUNTIES			
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
YAVAPAI, COCONINO, NAVAJO & APACHE COUNTIES			
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
GRAHAM, GREENLEE & COCHISE COUNTIES			
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
MOHAVE, LA PAZ & YUMA COUNTIES			
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
OUT OF STATE residents			
PPO: Beech Street	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$125.00

FAX TO 480-993-0007

Employee LAST NAME, FIRST NAME, M.I.		AFFILIATE #	
C. DENTAL PLAN (monthly costs listed)		<input type="checkbox"/> I DECLINE DENTAL COVERAGE	
		SINGLE	FAMILY
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
D. VISION COVERAGE (monthly costs listed)		<input type="checkbox"/> I DECLINE VISION COVERAGE	
AVESIS VISION PLAN		<input type="checkbox"/> \$6.34	<input type="checkbox"/> \$17.18
E. DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans			
	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
F. SHORT-TERM DISABILITY			
STANDARD SHORT-TERM DISABILITY		<input type="checkbox"/> DECLINE	<input type="checkbox"/> ELECT
UNUM PROVIDENT SHORT-TERM DISABILITY		<input type="checkbox"/> DECLINE	<input type="checkbox"/> OPTION A <input type="checkbox"/> OPTION B <input type="checkbox"/> OPTION C

FAX TO 480-993-0007

Employee LAST NAME, FIRST NAME, M.I.	AFFILIATE #
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G. PRIMARY BENEFICIARY		
		PRIMARY Percentage must = 100%
#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 %
List additional Beneficiaries or Trust information on Supplemental Page		

H. CONTINGENT BENEFICIARY		
		CONTINGENT Percentage must = 100%
#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 %

I. STANDARD EMPLOYEE SUPPLEMENTAL LIFE INSURANCE	STANDARD DEPENDENT SUPPLEMENTAL LIFE
<input type="checkbox"/> I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE <input type="checkbox"/> I Elect Coverage in the Amount of \$ _____ In increments of \$5,000 <input type="checkbox"/> I am a Non-Smoker for the last 6 months (additional \$1,000 benefit)	<input type="checkbox"/> I DECLINE DEPENDENT SUPPLEMENTAL COVERAGE <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

J. AETNA SUPPLEMENTAL LIFE INSURANCE
<input type="checkbox"/> I DECLINE AETNA SUPPLEMENTAL INSURANCE COVERAGE <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)

EMPLOYEE AUTHORIZATION AND SIGNATURE
<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>EMPLOYEE SIGNATURE _____</p> <p>DATE _____</p>

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

Employee LAST NAME, FIRST NAME, M.I.		AFFILIATE #	
ADDITIONAL BENEFICIARIES			
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	Payment %
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	Payment %
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	Payment %
TRUST OR LEGAL AGREEMENT			
Name of Trust or Legal Agreement			
Street, City, State, Zip Where Filed			
Date of Trust			
ADDITIONAL DEPENDENTS			
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
EMPLOYEE AUTHORIZATION AND SIGNATURE			
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 _____	