



2009-2010 BENEFITS ENROLLMENT

4 pages | **FAX to 480.993.0007**

Use for Benefits that take effect Oct. 1, 2009

Process New Hire Enrollment or Agency Transfer

1. All sections must be completed. Be sure to sign, date and print your Employee ID Number on each page of the enrollment form.

2. If the last name of your spouse is different from yours, you must submit a copy of your marriage license.

3. If the last names of your dependent children are different from yours, you will need to submit a copy of their birth certificates.

4. If your spouse is employed by ASU, the State of Arizona, University of Arizona, Northern Arizona University or ABOR, neither you nor your spouse can be covered under both plans.

5. Benefits Effective Date is the first of day of the pay period following enrollment—provided enrollment is within 31 days of the date of hire, the date when you became eligible for benefits or when you had a qualified life event.

6. You have 31 days from your Date of Hire in which to complete the enrollment form and submit it.

SUBMIT THE FORMS

Submit all completed forms and supporting documentation within 31 days of your Date of Hire to:

**Office of Human Resources
Benefits Design & Management**
Confidential E-fax
480.993.0007



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 3-page form | **FAX to 480.993.0007** For Benefits effective Oct. 1, 2009

<input type="checkbox"/> NEW EMPLOYEE		<input type="checkbox"/> QUALIFIED LIFE EVENT		<input type="checkbox"/> AGENCY TRANSFER AGENCY NAME _____	
EMPLOYEE IDENTIFICATION				DATE RECEIVED: _____	
LAST NAME, FIRST NAME, MI		EMPLOYEE EIN or SSN		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
STREET ADDRESS		COUNTY OF RESIDENCE		BIRTHDATE	DATE OF HIRE
CITY/STATE/ZIP		WORK PHONE # ()		HOME PHONE # ()	
Are you enrolling a Domestic Partner (Circle One):				YES	NO
Do you claim your Domestic Partner on your IRS Tax Return (Circle One):				YES	NO
Are you enrolling an Older Child(ren) that is/are neither a full-time student(s) nor disabled dependent(s) (Circle One):				YES	NO
Do you claim your Child(ren) on your IRS Tax Return (Circle One):				YES	NO
If you have already enrolled a qualified domestic partner or older child, you do not need to submit additional paperwork. If you want to add a domestic partner or older child during open enrollment, please visit BENEFITS ONLINE for info: Domestic Partner and Children coverage: www.asu.edu/hr/benefits/dompartnerandchildren.html Older Children coverage: www.asu.edu/hr/benefits/olderchildcoverage.html					
MEDICAL PLANS (Employee Monthly Cost Listed)			<input type="checkbox"/> I DECLINE MEDICAL COVERAGE.		
EPO PLANS		EE ONLY	EE + ADULT	EE + CHILD	EE + FAMILY
AETNA CHOICE II (Open Access)		<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15
AMERIBEN		<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15
CIGNA OPEN ACCESS PLUS ONLY		<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15
UNITED HEALTHCARE SELECT		<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46	<input type="checkbox"/> \$82.15
PPO PLANS		EE ONLY	EE + ADULT	EE + CHILD	EE + FAMILY
AETNA SELECT (Open Access)		<input type="checkbox"/> \$71.08	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62	<input type="checkbox"/> \$204.46
AMERIBEN		<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62	<input type="checkbox"/> \$204.46
UNITED HEALTHCARE OPTIONS		<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62	<input type="checkbox"/> \$204.46
HSA OPTION WITH HEALTHFUND HASs —Cost will be PLUS HealthFund Election					
AETNA CHOICE POS II		<input type="checkbox"/> \$11.54+	<input type="checkbox"/> \$36.92+	<input type="checkbox"/> \$27.23+	<input type="checkbox"/> \$69.23+
DENTAL PLANS (Employee Monthly Cost Listed)			<input type="checkbox"/> I DECLINE DENTAL COVERAGE.		
		SINGLE	EE + 1	EE + FAMILY	
DELTA DENTAL		<input type="checkbox"/> \$13.78	<input type="checkbox"/> \$31.35	<input type="checkbox"/> \$54.52	
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$2.31	<input type="checkbox"/> \$4.15	<input type="checkbox"/> \$6.46	
VISION PLANS (Employee Monthly Cost Listed)			<input type="checkbox"/> I DECLINE VISION COVERAGE.		
AVESIS ADVANTAGE		<input type="checkbox"/> \$2.23	<input type="checkbox"/> \$6.24	<input type="checkbox"/> \$7.78	
AVESIS DISCOUNT PROGRAM If you waive the Advantage Program coverage, you will be automatically enrolled in the Discount Program and will get an Avesis discount card at no charge.					
EMPLOYEE NAME:			EIN/SSN:		
EFFECTIVE JAN. 1, 2009 All active state employees MUST provide social security numbers (SSNs) for all enrolled dependents.					



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The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and are to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performing these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that the Centers for Medicare & Medicaid Services has a long-standing practice of requesting SSNs or HICNs for coordination of benefit purposes.

DEPENDENTS

List ALL eligible dependents to be enrolled or unenrolled in medical, dental and/or vision plans

NOTE: List LAST NAME if different from employee

RELATIONSHIP CODES: S Spouse | C Child | D Domestic Partner | G Guardian | P Placed for Adoption

NAME Last/First/MI Use additional form if needed	BIRTH DATE (mm/dd/yy)	SOCIAL SECURITY NUMBER (REQUIRED)	RELATIONSHIP	MALE OR FEMALE M or F	FULL-TIME STUDENT Y or N	DISABLED Y or N	ADD OR DELETE A or D	PLAN TYPE MEDICAL (M) DENTAL (D) VISION (V)
EMPLOYEE								
SPOUSE								
DOMESTIC PARTNER								

OTHER DEPENDENTS

PRIMARY BENEFICIARY

CONTINGENT % MUST = 100%

#1 Beneficiary Last Name, First Name:		Payment %:
Social Security Number (OPTIONAL):		
Address:		
Phone:		
Relationship:		
Date of Birth:		
#2 Beneficiary Last Name, First Name:		Payment %:
Social Security Number (OPTIONAL):		
Address:		
Phone:		
Relationship:		
Date of Birth:		

CONTINGENT BENEFICIARY

CONTINGENT % MUST = 100%

#1 Beneficiary Last Name, First Name:		Payment %:
Social Security Number (OPTIONAL):		
Address:		
Phone:		
Relationship:		



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Date of Birth:		
#2 Beneficiary Last Name, First Name:		Payment %:
Social Security Number (OPTIONAL):		
Address:		
Phone:		
Relationship:		
Date of Birth:		

SHORT-TERM DISABILITY

The Hartford	<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

THE HARTFORD EMPLOYEE SUPPLEMENTAL LIFE INSURANCE		THE HARTFORD DEPENDENT LIFE INSURANCE	
<input type="checkbox"/> I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE		<input type="checkbox"/> I DECLINE DEPENDENT LIFE COVERAGE	
<input type="checkbox"/> I ELECT coverage in the amount of \$ _____ (\$5000 increments) up to three times your annual salary or \$300,000, whichever is less		I elect coverage in the amount of:	
<input type="checkbox"/> I am a NON-SMOKER for the last 6 months (additional \$1000 benefit)		<input type="checkbox"/> \$2000 \$0.94/month	<input type="checkbox"/> \$12,000 \$5.64/month
<input type="checkbox"/> NO CHANGE		<input type="checkbox"/> \$4000 \$1.88/month	<input type="checkbox"/> \$15,000 \$7.06/month
		<input type="checkbox"/> \$6000 \$2.82/month	<input type="checkbox"/> \$50,000 \$24.25/month
		<input type="checkbox"/> NO CHANGE	

AETNA EMPLOYEE SUPPLEMENTAL LIFE INSURANCE		AETNA DEPENDENT LIFE INSURANCE	
<input type="checkbox"/> I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE		<input type="checkbox"/> I DECLINE DEPENDENT LIFE COVERAGE	
<input type="checkbox"/> I ELECT coverage in the amount of \$ _____ 1, 2 OR 3 times my annual salary or \$500,000, whichever is less, without evidence of good health. Amounts \$500,000 to \$1 million require evidence of good health.		Spouse \$5,000 / Child(ren) \$2500	\$1.05/pay period \$2.28/month
<input type="checkbox"/> I am a NON-SMOKER for the last 6 months		Spouse \$10,000 / Child(ren) \$5,000	\$3.16/pay period \$6.84/month
<input type="checkbox"/> NO CHANGE		Spouse \$25,000 / Child(ren) \$12,500	\$5.26/pay period \$11.39/month
		Spouse \$50,000* / Child(ren) \$25,000 Requires Evidence of Good Health	\$10.52/pay period \$22.79/month
		<input type="checkbox"/> NO CHANGE	

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/domestic partner and/or dependent information is accurate. 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, 12-2311, 12-2702 and other applicable provisions of the law. In addition, I have read and understand the declarations.

SIGNATURE	DATE