



# BENEFITS DECLARATION FOR CHANGE

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

NAME \_\_\_\_\_

EMPL ID #(10 Digits) \_\_\_\_\_

<b>DEPENDENTS</b>	
<b>Add Spouse</b> Marriage Loses eligibility for Medicare Loses eligibility for AHCCCS Loses coverage with own employer Goes through Open Enrollment with own employer Domestic Partner (Need to attach application and supporting documentation)	<b>Remove Spouse</b> Legal annulment – Include spouse new address Legal separation – Include spouse new address Divorce or dissolves Domestic Partnership – Include Spouse or Domestic Partner new address Becomes eligible for Medicare Becomes eligible for AHCCCS Gains coverage with own employer Death of spouse
<b>Add Child</b> Birth, Placement for Adoption or Adoption Guardianship or Foster Care Domestic Partner Child (not a full time student) Older child (not full time student) Qualified Medical Child Support Order Becomes full-time student Loses eligibility for Medicare Loses eligibility for AHCCCS Loses coverage from another qualified plan	<b>Remove Child</b> Marries Reaches age 19 & is not a full-time student nor meets Older Child criteria – Include address Ceases to be a full-time student Full-time student or Older Child reaches age 25 - Include address Loss of guardianship Loss of foster care Qualified Medical Child Support Order rescinded Gains coverage with own employer Death of child
<b>EMPLOYEE</b>	<b>MISCELLANEOUS</b>
Becomes Full-Time or Regular Becomes Part-Time or Temporary Goes on Un-Paid Leave Returns from Un-Paid Leave Loses coverage elsewhere Gains coverage elsewhere	Cancel Short-Term Disability Cancel Dependent Supplemental Life Change Flexible Spending Account Address Change Other (Be specific) _____
<b>DOCUMENTATION REQUIRED (AS APPLICABLE)</b> In English or with translation – Copies are acceptable Documentation MUST INCLUDE the event date or effective date for loss or gain of coverage.	
<ul style="list-style-type: none"> <li>❖ Marriage license (for marriage or if spouse has different last name)</li> <li>❖ Birth certificate (for birth or if children have different last name)</li> <li>❖ Application for birth certificate or official hospital birth record</li> <li>❖ Letter from Medicare, AHCCCS or other company plan sponsor</li> <li>❖ Any official, signed and dated documentation supporting request</li> <li>❖ Submit Qualified Domestic Partner Affidavit, Declaration of Tax Status and 3 separate pieces of documentation</li> <li>❖ Submit Older Child and/or Domestic Older Child Declaration of Tax Status</li> </ul> <ul style="list-style-type: none"> <li>❖ Enrollment Form</li> <li>❖ Insurance ID card</li> <li>❖ HIPAA certificate</li> <li>❖ Annulment, separation or divorce decree</li> <li>❖ Death Certificate</li> </ul> <p><b>THIS FORM MUST BE RECEIVED WITHIN 31 DAYS OF THE EVENT.</b>  <b>In the case of marriage or birth, DO NOT submit this form prior to the event.</b>  <b>Do not delay submitting this form while you wait for documentation</b>  <b>(i.e. a marriage license from another state or country, the official birth certificate)</b></p>	

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 \_\_\_\_\_

<b>For Human Resources Use Only</b>		
Effective Date _____	Date Input _____	Input By _____

**FAX TO 480.993.0007**

Revised 12.31.08



# 2009-2010 BENEFITS ENROLLMENT (NEW HIRES)

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

<input type="checkbox"/> <b>NEW EMPLOYEE</b>	<input type="checkbox"/> <b>QUALIFIED LIFE EVENT</b>	<input type="checkbox"/> <b>AGENCY TRANSFER</b> <b>AGENCY NAME</b> _____	
<b>EMPLOYEE IDENTIFICATION</b>		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
<p>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 <b>BENEFITS ONLINE</b> for info:  <b>Domestic Partner and Children coverage:</b> <a href="http://www.asu.edu/hr/benefits/dompartnerandchildren.html">www.asu.edu/hr/benefits/dompartnerandchildren.html</a>  <b>Older Children coverage:</b> <a href="http://www.asu.edu/hr/benefits/olderchildcoverage.html">www.asu.edu/hr/benefits/olderchildcoverage.html</a></p>			
<b>MEDICAL PLANS (Employee Monthly Cost Listed)</b>		<input type="checkbox"/> <b>I DECLINE MEDICAL COVERAGE.</b>	
<b>EPO PLANS</b>	<b>EE ONLY</b>	<b>EE + ADULT</b>	<b>EE + CHILD</b>
<b>AETNA CHOICE II (Open Access)</b>	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
<b>AMERIBEN</b>	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
<b>CIGNA OPEN ACCESS PLUS ONLY</b>	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
<b>UNITED HEALTHCARE SELECT</b>	<input type="checkbox"/> \$18	<input type="checkbox"/> \$44.77	<input type="checkbox"/> \$36.46
<b>PPO PLANS</b>	<b>EE ONLY</b>	<b>EE + ADULT</b>	<b>EE + CHILD</b>
<b>AETNA SELECT (Open Access)</b>	<input type="checkbox"/> \$71.08	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62
<b>AMERIBEN</b>	<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62
<b>UNITED HEALTHCARE OPTIONS</b>	<input type="checkbox"/> \$71.06	<input type="checkbox"/> \$151.38	<input type="checkbox"/> \$142.62
<b>HSA OPTION WITH HEALTHFUND HASs —Cost will be PLUS HealthFund Election</b>			
<b>AETNA CHOICE POS II</b>	<input type="checkbox"/> \$11.54+	<input type="checkbox"/> \$36.92+	<input type="checkbox"/> \$27.23+
<b>DENTAL PLANS (Employee Monthly Cost Listed)</b>		<input type="checkbox"/> <b>I DECLINE DENTAL COVERAGE.</b>	
	<b>SINGLE</b>	<b>EE + 1</b>	<b>EE + FAMILY</b>
<b>DELTA DENTAL</b>	<input type="checkbox"/> \$13.78	<input type="checkbox"/> \$31.35	<input type="checkbox"/> \$54.52
<b>TOTAL DENTAL ADMINISTRATORS</b>	<input type="checkbox"/> \$2.31	<input type="checkbox"/> \$4.15	<input type="checkbox"/> \$6.46
<b>VISION PLANS (Employee Monthly Cost Listed)</b>		<input type="checkbox"/> <b>I DECLINE VISION COVERAGE.</b>	
<b>AVESIS ADVANTAGE</b>	<input type="checkbox"/> \$2.23	<input type="checkbox"/> \$6.24	<input type="checkbox"/> \$7.78
<b>AVESIS DISCOUNT PROGRAM</b>			
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.			
<b>EMPLOYEE NAME:</b>		<b>EIN/SSN:</b>	
<b>EFFECTIVE JAN. 1, 2009</b> All active state employees MUST provide social security numbers (SSNs) for all enrolled dependents.			



# 2009-2010 BENEFITS ENROLLMENT (NEW HIRES)

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

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 <b>(REQUIRED)</b>	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%**

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

## CONTINGENT BENEFICIARY

**CONTINGENT % MUST = 100%**

<b>#1 Beneficiary Last Name, First Name:</b>		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**

<b>The Hartford</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

<b>THE HARTFORD EMPLOYEE SUPPLEMENTAL LIFE INSURANCE</b>		<b>THE HARTFORD DEPENDENT LIFE INSURANCE</b>	
<input type="checkbox"/> <b>I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE</b>		<input type="checkbox"/> <b>I DECLINE DEPENDENT LIFE COVERAGE</b>	
<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	

<b>AETNA EMPLOYEE SUPPLEMENTAL LIFE INSURANCE</b>		<b>AETNA DEPENDENT LIFE INSURANCE</b>	
<input type="checkbox"/> <b>I DECLINE EMPLOYEE SUPPLEMENTAL COVERAGE</b>		<input type="checkbox"/> <b>I DECLINE DEPENDENT LIFE COVERAGE</b>	
<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