



2015

ENROLLMENT FORM
ARIZONA STATE RETIREMENT SYSTEM
ATTN: HEALTH INSURANCE
P.O. BOX 33910
PHOENIX, AZ 85067

Effective Date: 1st of _____, 2015
MONTH

Reason for Enrollment Form:

- OPEN ENROLLMENT (Applicable to ASRS Open Enrollment only)
NEW RETIREE - RETIREMENT DATE: ___/___/___
QUALIFYING EVENT: _____ (as defined in ASRS Initial Enrollment Guide)

Official Use Only
Recorded: _____
Keyed: _____
Verified: _____

Status:
RETIRED
DISABLED
SURVIVING DEPENDENT

Form fields for personal information: SOCIAL SECURITY NUMBER, LAST NAME, FIRST NAME, MI, DATE OF BIRTH, PRIMARY RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE, MAILING ADDRESS, PHONE NUMBER, COUNTY OF RESIDENCE, IS THIS A CHANGE OF ADDRESS, GENDER, CURRENT MARITAL STATUS, NAME OF FORMER EMPLOYER, MEMBER OF, ARE YOU ENROLLING A DOMESTIC PARTNER?

MEDICAL INSURANCE PLANS

I'M DECLINING MEDICAL COVERAGE

WITHOUT MEDICARE

You and your dependents do not have Medicare Part A and B

ALL ARIZONA COUNTIES

Table with 2 columns: Coverage Type (Single/Family) and Premium (\$740.00/\$1480.00 for Arizona, \$1035.00/\$2070.00 for Out of State)

WITH MEDICARE A & B

You and your dependent(s) have Medicare Part A and B

ALL ARIZONA COUNTIES

Table with 2 columns: Coverage Type (Single/Family) and Premium (\$194.00/\$388.00 for Arizona, \$337.00/\$674.00 for Out of State)

COMBINATION PLANS

One person on Medicare, the other(s) without Medicare

Two people on Medicare, the other(s) without Medicare

ALL ARIZONA COUNTIES

Table with 2 columns: Coverage Type (Single/Family) and Premium (\$934.00/\$1128.00 for Arizona, \$1077.00/\$1414.00 for Out of State)

(1) A domestic partner is a legal or personal relationship between two individuals who live together but are neither joined by a traditional marriage or civil union. To add a domestic partner to your coverage, you must also complete the Qualified Domestic Partner Certification form.
(2) Retiree and dependents monthly premium is a multiple of the number of lives covered and the single coverage premium.
(3) The Senior Supplement medical plan can only be selected in conjunction with the Prescription Drug Plan (PDP). If you are currently enrolled in the Senior Supplement medical plan and you elect to cancel your medical plan coverage, your Medicare Part D Prescription drug coverage will be cancelled as well.

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER
-----------	------------	----	------------------------

DENTAL INSURANCE PLANS		<input type="checkbox"/> I'M DECLINING DENTAL COVERAGE		
Assurant Employee Benefits	Member			Dentist ID Number (Facility ID number can be found in Assurant Directory)
	Single Coverage	+ 1 Dependent	+ 2 dependents or more	
Freedom Advance (High Option) (Nationwide coverage)	<input type="checkbox"/> \$35.51 per month	<input type="checkbox"/> \$70.87 per month	<input type="checkbox"/> \$100.29 per month	NOT APPLICABLE
Freedom Basic (Low Option) (Nationwide coverage)	<input type="checkbox"/> \$16.67 per month	<input type="checkbox"/> \$35.25 per month	<input type="checkbox"/> \$64.54 per month	NOT APPLICABLE
DHMO 220 Prepaid Plan with Ortho Copays (Available in Arizona only)	<input type="checkbox"/> \$13.96 per month	<input type="checkbox"/> \$23.34 per month	<input type="checkbox"/> \$39.23 per month	
Heritage Secure Prepaid Plan w/SBA (Available in Arizona only)	<input type="checkbox"/> \$10.61 per month	<input type="checkbox"/> \$17.41 per month	<input type="checkbox"/> \$26.90 per month	
Prepaid (Available in CA, CO, FL, GA, KS, MO, NE, NV, NM, OH, OK, OR, TX and UT)	<input type="checkbox"/> \$10.21 per month	<input type="checkbox"/> \$17.27 per month	<input type="checkbox"/> \$27.24 per month	

PLEASE LIST ALL ELIGIBLE INDIVIDUALS TO BE ENROLLED IN MEDICAL AND/OR DENTAL PLAN							
	Last Name	First Name	MI	Sex	Social Security Number	Date of Birth Mo/Day/Yr	Medicare Claim Number (if applicable)
Primary Member							
Spouse							
Domestic Partner (1)							
Dependent							
Dependent							
Dependent							
Dependent							

ATTENTION: <i>If you and/or your dependents are enrolling in the <u>UnitedHealthcare Group Medicare Advantage HMO</u>, you will need to select a Primary Care Physician.</i> <i>If you do not list a medical doctor, one will be automatically assigned to you.</i>	Covered Person Name	Physician Name	Network Name	Do you have End Stage Renal Disease (ESRD)? Yes/No (4)

(4) If you have End Stage Renal Disease (ESRD), you may not be eligible to enroll in the UnitedHealthcare Group Medicare Advantage HMO at this time. Please contact an on-site UnitedHealthcare representative for further information at (602) 240-2113 Monday through Friday 8:00AM to 5:00PM MST.

I request enrollment in the Arizona State Retirement System (ASRS) Retiree Group Insurance Program and verify the information that I've provided is true and accurate. I hereby authorize premium deductions to be taken from my monthly retirement check if sufficient to cover the premium; otherwise, I understand I will be required to make premium payments directly to the insurance carrier. If either I or my dependent(s) are enrolled in Medicare and are enrolling in the Group Medicare Advantage HMO or the Senior Supplement Plan with UnitedHealthcare MedicareRx for Groups Prescription Drug Coverage, I understand that this enrollment form must be received by the ASRS prior to the requested effective date of coverage. I understand that if I'm changing coverage due to a temporary address change, it is my responsibility to notify the ASRS of my impending return.

Primary Member Signature: _____ Date: _____

Official Use Only:



2015 ENROLLMENT FORM

ARIZONA STATE RETIREMENT SYSTEM
ATTN: HEALTH INSURANCE
P.O. BOX 33910
PHOENIX, AZ 85067

ENROLLMENT FORM INSTRUCTIONS

Complete an ASRS Enrollment Form if you are enrolling for the first time, electing new coverage, or changing your existing coverage. Submission of a properly completed Enrollment Form is required to enroll in an ASRS medical and/or dental plan. Please complete the Enrollment Form as outlined below:

Step 1

- Effective Date: Fill in the month that you need the insurance coverage to begin. Effective date of your coverage will be the first of the month following receipt of the Enrollment Form unless a future date is provided. January 1, 2015 is the effective date for the 2015 Open Enrollment.
- Check boxes that apply to you:
Reason for Enrollment Form Status

Step 2

- Provide your social security number, name, address, etc. If you want your mail sent to a different mailing address then your primary residence, complete the mailing address line.

Step 3

- If you are enrolling in a medical plan, check the box of the medical plan you are electing. You can only select one option. If you are not enrolling in medical, check box that states: "I'M DECLINING MEDICAL COVERAGE".
- If you are enrolling in a dental plan, check the box of the dental plan you are electing. You can only select one option. If you are not enrolling in dental, check box that states: "I'M DECLINING DENTAL COVERAGE".

Step 4

- List yourself and all other eligible dependents that you are enrolling in the medical and/or dental plan(s).
- If you are electing the dental Prepaid DHMO, Heritage Secure or Out of State Prepaid plan, you must provide a Dentist ID number or a dentist will be automatically assigned to you. If you are unsure what to include, you can find the dentist directory at www.assurantemployeebenefits.com/ASRS or by calling (800) 443-2995.
- Group Medicare Advantage HMO only: List the names of the persons enrolling in this plan in the Covered Person Name box; indicate the name(s) of the Primary Care Physician(s) and Network(s) you are choosing. If you are unsure what to include, you can find the Group Medicare Advantage HMO directory at www.uhcretiree.com/ASRS or you can call (866) 208-3248.

Step 5

- Sign and date the Enrollment Form. Signature must be from either the retiree, disabled member or a surviving dependent.
- If you are enrolling in a Medicare plan, please provide a copy of your Medicare card or an award letter showing you are eligible for Medicare.
- If you are enrolling mid-year (a time other than Open Enrollment period) in a medical and/or dental insurance plan, please provide proof of the qualifying event that you are experiencing. If you are unsure on what to provide, you may contact ASRS Member Services at (602) 240-2000 in Phoenix, (520) 239-3100 in Tucson or outside of Phoenix and Tucson, at (800) 621-3778.
- **KEEP THE GOLDENROD COPY OF THE ENROLLMENT FORM FOR YOUR OWN RECORDS.**
- Mail your Enrollment Form to:

Arizona State Retirement System
Attn: Health Insurance
PO Box 33910
Phoenix, AZ 85067

If you are terminating your current ASRS medical and/or dental coverage, please send a letter in writing to ASRS, with the retiree, disabled member or surviving spouse's social security number and your signature. If you and/or your dependents are terminating an ASRS Medicare plan, please include all covered members' signatures.