



Your investment.
Your future.
Secure for your lifetime.

Health Insurance Premium Benefit Program

Presenter: Sarah Tucker

Program & Eligibility

- Health Insurance Premium Benefit
- Eligibility
- How is HIPB applied



HIPB Forms

- Health Insurance Premium Benefit Authorization Form
- Health Insurance Change/Deletion Form
- Reimbursement of Medical and/or Dental Cost Instructions Form



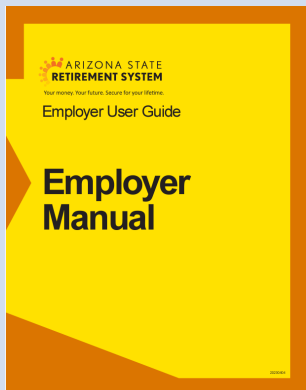
Reconciliation Report

- Where to find reports
- Adjustments & Overpayments
- Review of HI 460 Samples



RESOURCES

Employer Manual



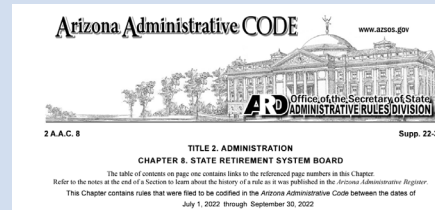
Employer Manual
Section 9

State Statute



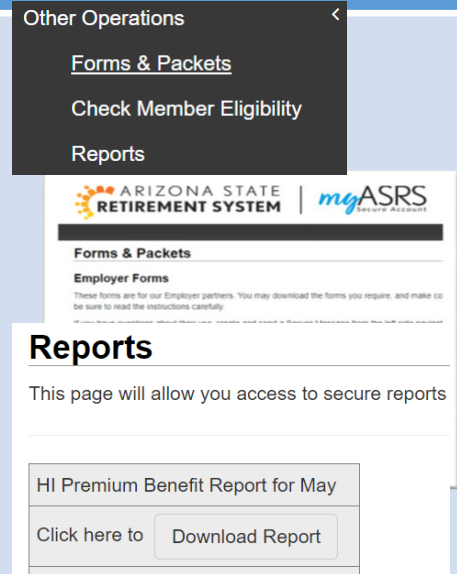
A.R.S. § 38-783 – Retired members; dependents; health insurance; premium payment; separate accounts; definitions

Arizona Administrative Code



Title 2
Administration
Chapter 8
State Retirement System
Board

Secure Website



<https://secure.azasrs.gov>

ASRS HEALTH INSURANCE

- Coverage offered to retirees and LTD recipients
- Medical and Dental
- Non-Medicare and Medicare supplement plans

<https://www.azasrs.gov/content/health-care>

Healthcare



Healthcare

The ASRS offers medical insurance, dental insurance, and a prescription drug discount card program for retirees and their qualified dependents. Online health insurance enrollment is accessible from [your secure myASRS account](#). The process is quick, safe, and easy.

[Health Plan WRAP Document](#)

Retiree Health Insurance Survey

Want to give feedback on our Medicare, non-Medicare, or dental plans?

[Click here to launch our survey!](#)



Medicare Plans

Information and plans for retiree health insurance for members who have met Medicare eligibility.



Non-Medicare Plans

Information and plans for retiree health insurance for members who have not met Medicare eligibility.
[2024 Tax Form 1095-B Information](#)



Dental Plans

Information and plans for retiree dental insurance plans offered through Cigna Dental and Delta Dental of Arizona.



Becoming Medicare Eligible

If you or your dependent(s), will become Medicare eligible soon, there are some things to consider as plan options, premiums, premium benefit and coverages will change.



ASRS Premium Benefit

Additional benefits to help offset the cost of health insurance.



Qualifying Life Events

Information on qualifying life events and coverage eligibility.

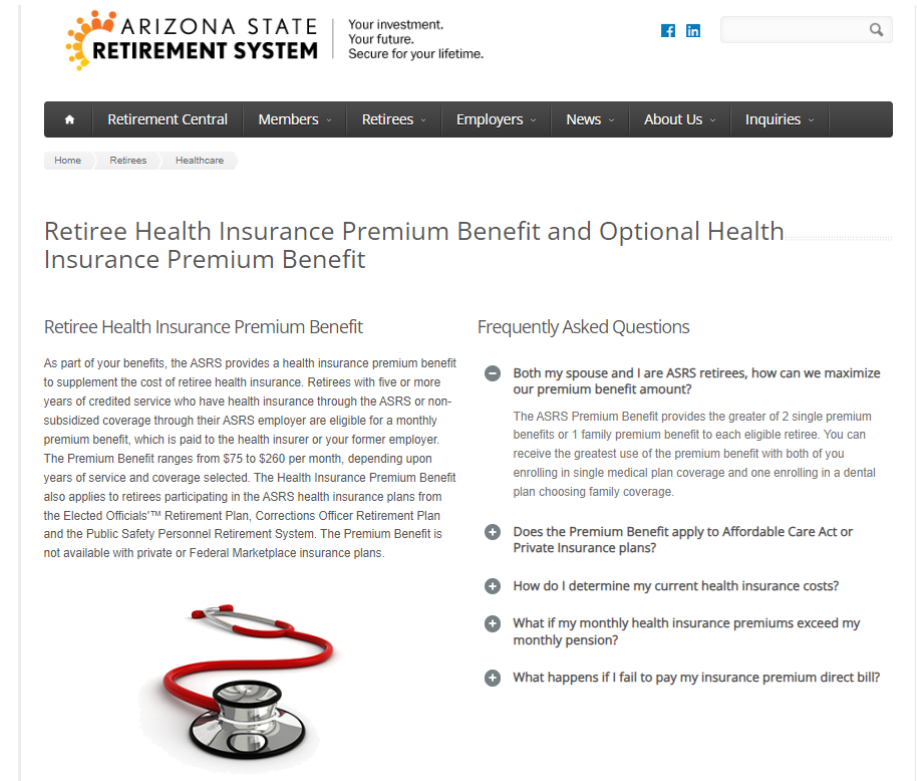


2025 Healthcare Plan Videos

On-demand videos explaining everything you need to know about Medicare, Non-Medicare, and Dental plans for 2025 coverage.

ASRS HEALTH INSURANCE PREMIUM BENEFIT PROGRAM

- Additional benefit for eligible ASRS retirees
- Medical/dental coverage through ASRS
- Medical/dental **unsubsidized** group coverage through ASRS employer



The screenshot shows the Arizona State Retirement System website. The header includes the ASRS logo, the tagline "Your investment. Your future. Secure for your lifetime.", and social media icons for Facebook and LinkedIn. A navigation menu contains links for Retirement Central, Members, Retirees, Employers, News, About Us, and Inquiries. Below the menu, there are tabs for Home, Retirees, and Healthcare. The main content area is titled "Retiree Health Insurance Premium Benefit and Optional Health Insurance Premium Benefit". It features a section for "Retiree Health Insurance Premium Benefit" with a detailed paragraph explaining the benefit. To the right, there is a "Frequently Asked Questions" section with four questions, each preceded by a plus sign icon. At the bottom of the page, there is an image of a red stethoscope.

<https://www.azasrs.gov/content/retiree-health-insurance-premium-benefit-and-optional-health-insurance-premium-benefit>

ASRS Contribution Rates

Fiscal Year 2024-2025 (Effective 7/1/2024)

	Retirement Pension	Health Insurance Benefit	Long Term Disability Income Plan	Total
Employee	12.12%	n/a	0.15%	12.27%
Employer	12.05%	0.07%	0.15%	12.27%
Employer-only ACR	10.14%	0.00%	0.05%	10.19%

ASRS HEALTH INSURANCE PREMIUM BENEFIT ELIGIBILITY

To be eligible, the ASRS member must:

- Be retired or approved for Long Term Disability, **and**
 - Have at least 5 years of service, **and**
 - Be enrolled in an ASRS health insurance plan,
- or**
- Be enrolled in an ASRS employer's unsubsidized health insurance plan

<https://www.azasrs.gov/content/retiree-health-insurance-premium-benefit-and-optional-health-insurance-premium-benefit>

HEALTH INSURANCE PREMIUM TABLE

Years of Service	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without
Arizona State Retirement System (ASRS) Members						
5.0–5.9	\$75.00	\$130.00	\$50.00	\$85.00	\$107.50	\$107.50
6.0–6.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
7.0–7.9	\$105.00	\$182.00	\$70.00	\$119.00	\$150.50	\$150.50
8.0–8.9	\$120.00	\$208.00	\$80.00	\$136.00	\$172.00	\$172.00
9.0–9.9	\$135.00	\$234.00	\$90.00	\$153.00	\$193.50	\$193.50
10.0+	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0–5.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
6.0–6.9	\$112.50	\$195.00	\$75.00	\$127.50	\$161.25	\$161.25
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<i>not applicable</i>	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Public Safety Personnel Retirement System (PSPRS) Members						
<i>not applicable</i>	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00

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"GREATER OF" SCENARIO

- Both retiree & retired dependent are ASRS members with 10 yrs of service.
- Both are eligible for an individual PB of \$150 each totaling \$300.

\$300 > \$260

The retiree carrying the dependent will receive the **greater of** the two options.

Service	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
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DUAL RETIREES OF ASRS, PSPRS, CORP & EORP

Years of Service	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
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Member retired with 10 years of service from ASRS, and also retired from PSPRS = Dual Retiree

ASRS Premium Benefit = \$150
PSPRS Premium Benefit = \$150

Dual retiree enrolls in HI through PSPRS

PSPRS PB + ASRS PB = \$300

DUAL RETIREES OF ASRS, PSPRS, CORP & EORP

Greater of Scenario

Dual retiree with a dependent who is also an ASRS & eligible for a PB:

PSPRS will only pay up to their family premium benefit.

ASRS will pay the dual retiree any difference directly.

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OPTIONAL HEALTH INSURANCE PREMIUM BENEFIT

Years of Service	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
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Corrections Officer Retirement Plan (CORP) Members						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Public Safety Personnel Retirement System (PSPRS) Members						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00

- OHIPB is an option for retirees who elect a Joint & Survivor Annuity option or a Term Certain Annuity Option.
- OHIPB reduces the premium benefit to provide a continuing PB to the member's contingent annuitant (survivor beneficiary).
- Can only be elected at the time of retirement.
- Can terminate election anytime after retirement.
- Termination of OHIPB is irrevocable.

<https://www.azasrs.gov/content/calculating-your-optional-premium-benefit>

HOW IS THE PREMIUM BENEFIT APPLIED?

ASRS HEALTH INSURANCE

Premium Benefit applied via monthly pension payment

If pension amount cannot cover net cost, or member is on LTD, the member is direct billed.

EMPLOYER HEALTH INSURANCE

Premium Benefit is either:

Paid directly to employer

OR

Paid as a reimbursement to retiree every 6 months if eligible

HOW IS THE PREMIUM BENEFIT APPLIED TO ADOA HEALTH INSURANCE?

ADOA RETIREE INSURANCE

Premium Benefit added to Pension

If Pension amount cannot cover net cost, or member is on LTD, the member is direct billed.

ADOA COBRA

6-Month Reimbursement Form regardless of retirement date



WHO DO ADOA RETIREES CONTACT?

**QUESTIONS ABOUT ADOA HEALTH
INSURANCE ENROLLMENT & COVERAGE
OR COMPLETING/SUBMITTING THE 6 MO
REIMBURSEMENT FORM**

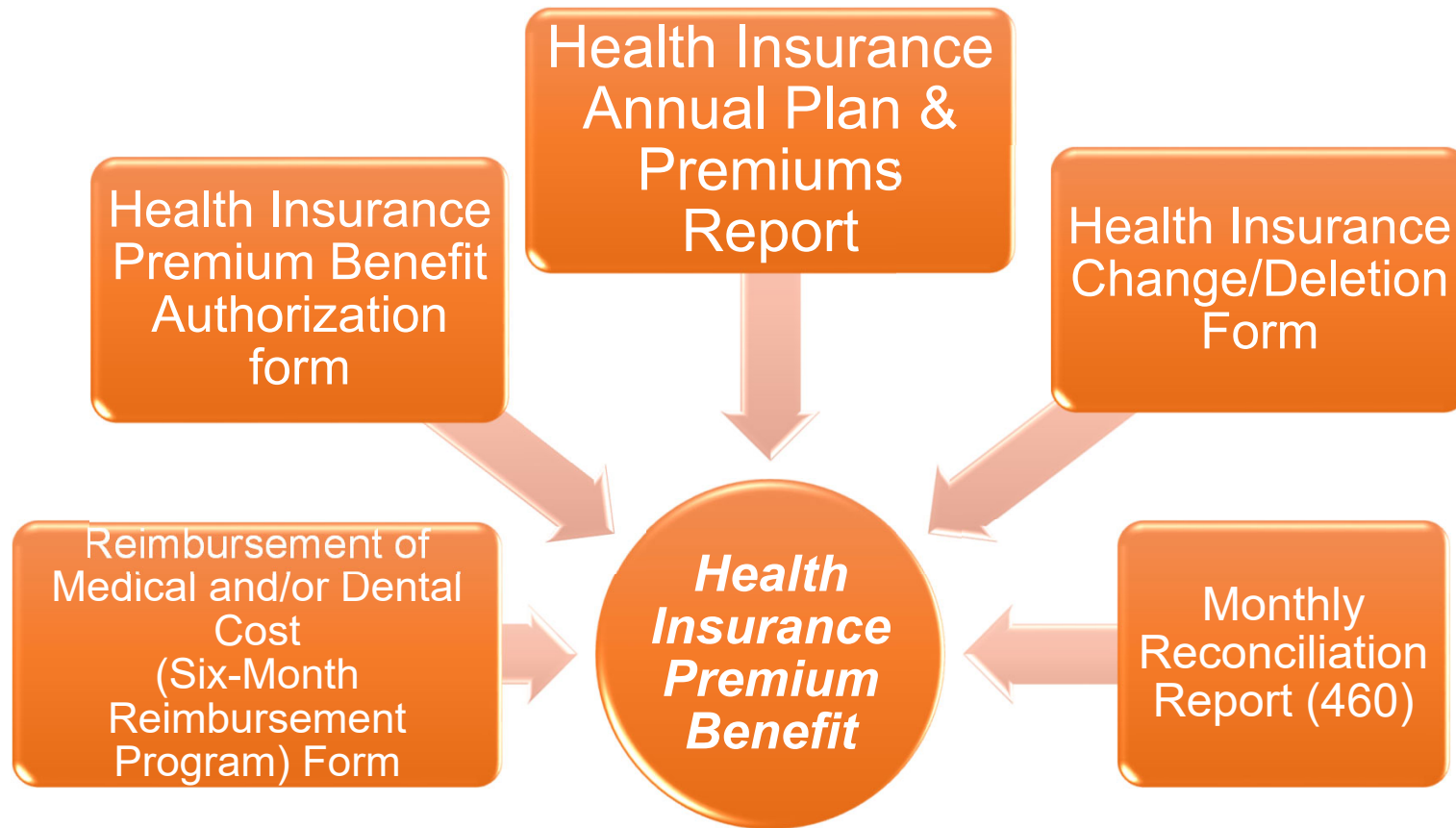
ADOA Benefit Options
benefitoptions.az.gov
(602) 542-5008
(800) 304-3687

**QUESTIONS ABOUT THEIR
PREMIUM BENEFIT AMOUNT
OR PAYMENT**

ASRS Member Advisory Center
secure.azasrs.gov
602-240-2000 from within metropolitan Phoenix
520-239-3100 from within metropolitan Tucson
800-621-3778 from outside the Tucson and
Phoenix areas

QUESTIONS?

EMPLOYER RESPONSIBILITIES



Annual Employer Provided Health Insurance Plans & Premiums Report (PPR)



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
Annual Employer Provided Health
Insurance Plans and Premiums Report

COMPLETE AND SEND TO THE ASRS
VIA EMPLOYER SECURE MESSAGING
www.asrs.gov

Employer Name:	ASRS Employer ID:
Reports Manager/Hi Premium Benefit Specialist Name:	Phone #:
Email Address:	Fax #:

Employer Open Enrollment Information

Open Enrollment Begins:	Open Enrollment Ends:
Effective date of plan year:	
Are there changes to ANY of your medical or dental plans OR premiums? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Changes to: Medical <input type="checkbox"/> Dental <input type="checkbox"/> Both <input type="checkbox"/>	
Please sign below and complete the Employer Health Insurance Plan/Premium Breakdown Table on the following page(s).	
<input type="checkbox"/> Check if there ARE NO CHANGES to ANY of your retiree medical or dental plans OR premiums	
If no changes, simply sign below and return only this sheet. ASRS will continue the current plans and premiums into the next plan year.	

IMPORTANT:

****CHANGE/DELETE forms ARE required for all retirees who are changing plans, adding or deleting dependents, or cancelling any or all of their Medical or Dental elections***

****CHANGE/DELETE forms ARE NOT required if the retiree/member is not making any changes to their current coverage****

_____ Reports Manager/Hi Premium Benefit Specialist Signature	_____ Date
--	---------------

Revised 01/29/2020



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
Employer Health Insurance
Plan/Premium Breakdown Table

Employer Name:	ASRS Employer ID:
Name of Person completing this form:	
Email Address:	Phone:

Please provide plan detail below. List ONE plan per form

Plan type: (check all that apply)	<input checked="" type="checkbox"/> COBRA MEDICAL	<input type="checkbox"/> COBRA DENTAL	
	<input type="checkbox"/> RETIREE MEDICAL	<input type="checkbox"/> RETIREE DENTAL	
Carrier/Vendor Name (e.g.: Aetna, UHC, BCBS):	_____		
Is this a new Carrier?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Detailed plan name:	_____		
(e.g.: PPO \$1500, BUY UP, HDHP, etc.)			
IS ANY PORTION OF THIS PREMIUM BEING PAID BY THE EMPLOYER?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
NOTE: For retirees who retired after August 2, 2012: Active employee insurance that is subsidized by the employer is not eligible for Premium Benefit Payments. An employer-subsidized plan means a portion of the total premium is paid by the employer. (A.R.S. § 38-783).			
	OLD MONTHLY PREMIUM	NEW MONTHLY PREMIUM	NO Change
RETIREE ONLY			<input type="checkbox"/>
RETIREE PLUS SPOUSE			<input type="checkbox"/>
RETIREE PLUS 1 (child)			<input type="checkbox"/>
RETIREE PLUS FAMILY (2 or more)			<input type="checkbox"/>

Revised 01/29/2020

Annual Employer Provided Health Insurance PPR



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
Annual Employer Provided Health
Insurance Plans and Premiums Report

COMPLETE AND SEND TO THE ASRS
VIA EMPLOYER SECURE MESSAGING
www.asrs.gov

Employer Name:	ASRS Employer ID:
Reports Manager/Hi Premium Benefit Specialist Name:	Phone #:
Email Address:	Fax #:
Employer Open Enrollment Information	
Open Enrollment Begins:	Open Enrollment Ends:
Effective date of plan year:	
Are there changes to ANY of your medical or dental plans OR premiums? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Changes to: Medical <input type="checkbox"/> Dental <input type="checkbox"/> Both <input type="checkbox"/>	
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Reports Manager/Hi Premium Benefit Specialist Signature	Date

Revised 01/29/2020

Employer Open Enrollment Information	
Open Enrollment Begins:	Open Enrollment Ends:
Effective date of plan year:	
Are there changes to ANY of your medical or dental plans OR premiums? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Changes to: Medical <input type="checkbox"/> Dental <input type="checkbox"/> Both <input type="checkbox"/>	
Please sign below and complete the Employer Health Insurance Plan/Premium Breakdown Table on the following page(s).	
<input type="checkbox"/> Check if there ARE NO CHANGES to ANY of your retiree medical or dental plans OR premiums	
If no changes, simply sign below and return only this sheet. ASRS will continue the current plans and premiums into the next plan year.	



Annual Employer Provided Health Insurance PPR Plan/Premium Breakdown Table



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
Employer Health Insurance
Plan/Premium Breakdown Table

Employer Name:	ASRS Employer ID:
Name of Person completing this form:	
Email Address:	Phone:

Please provide plan detail below. List ONE plan per form

Plan type: (check all that apply) COBRA MEDICAL COBRA DENTAL
 RETIREE MEDICAL RETIREE DENTAL

Carrier/Vendor Name (e.g.: Aetna, UHC, BCBS): _____

Is this a new Carrier? YES NO

Detailed plan name: _____
 (e.g.: PPO \$1500, BUY UP, HDHP, etc.)

IS ANY PORTION OF THIS PREMIUM BEING PAID BY THE EMPLOYER? YES NO

NOTE: For retirees who retired *after* August 2, 2012: Active employee insurance that is subsidized by the employer is not eligible for Premium Benefit Payments. An employer-subsidized plan means a portion of the total premium is paid by the employer. (A.R.S. § 38-783).

	OLD MONTHLY PREMIUM	NEW MONTHLY PREMIUM	NO Change
RETIREE ONLY			<input type="checkbox"/>
RETIREE PLUS SPOUSE			<input type="checkbox"/>
RETIREE PLUS 1 (child)			<input type="checkbox"/>
RETIREE PLUS FAMILY (2 or more)			<input type="checkbox"/>

Revised 01/29/2020

Plan type: (check all that apply) COBRA MEDICAL COBRA DENTAL
 RETIREE MEDICAL RETIREE DENTAL

Difference between COBRA & Retiree Plans

COBRA Plan: An unsubsidized continuation of benefits for up to 18 months, for any employee who has terminated, but only those who are retired or on LTD are eligible for a premium benefit.

RETIREE PLAN: A specific insurance plan that, while it may have similar characteristics of an active employee plan, is in a separate unsubsidized bracket of benefits **exclusive to retirees only.**

Annual Employer Provided Health Insurance PPR

COMMON ISSUES

- Not submitting packet yearly.
 - It is important to send in this form every year, even if there are no changes.
- Only one PPR form is needed, but you may need multiple Breakdown Table sheets
- Change/Deletion forms are often not sent into ASRS in conjunction with the PPR.
- The form is not signed.



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
Annual Employer Provided Health
Insurance Plans and Premiums Report

COMPLETE AND SEND TO THE ASRS
VIA EMPLOYER SECURE MESSAGING
www.azasrs.gov

Employer Name:		ASRS Employer ID:	
Reports Manager/HI Premium Benefit Specialist Name:		Phone #:	
Email Address:		Fax #:	
Employer Open Enrollment Information			
Open Enrollment Begins:		Open Enrollment Ends:	
Effective date of plan year:			
Are there changes to ANY of your medical or dental plans OR premiums? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Changes to: Medical <input type="checkbox"/> Dental <input type="checkbox"/> Both <input type="checkbox"/>			

Employer Health Insurance Plan/Premium Breakdown Table

Please provide plan detail below. **List ONE plan per form**

Plan type: (check all that apply) COBRA MEDICAL COBRA DENTAL
 RETIREE MEDICAL RETIREE DENTAL

Carrier/Vendor Name (e.g.: Aetna, UHC, BCBS):

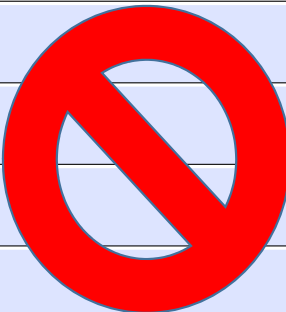
COMMON ISSUES

- Use one Breakdown Table for multiple plans.
- If offer multiple plans, even if only one plan change, we still need a breakout table for all plans.

Employer Health Insurance Plan/Premium Breakdown Table

REMINDER

- If a NEW plan is being added DO NOT enter the premium of the OLD plan. The Old Monthly Premium field should be left blank.

	OLD MONTHLY PREMIUM	NEW MONTHLY PREMIUM	NO Change
RETIREE ONLY			<input type="checkbox"/>
RETIREE PLUS SPOUSE			<input type="checkbox"/>
RETIREE PLUS 1 (child)			<input type="checkbox"/>
RETIREE PLUS FAMILY (2 or more)			<input type="checkbox"/>

Employer Health Insurance Plan/Premium Breakdown Table

COMMON ISSUE

- The Detailed Plan Name that is listed is different than the Detailed Plan Name for the year before, but it is not a plan change, it is a premium change only.

Carrier/Vendor Name (e.g.: Aetna, UHC, BCBS):

Is this a new Carrier?

YES

NO

Detailed plan name:

(e.g.: PPO \$1500, BUY UP, HDHP, etc.)

HEALTH INSURANCE PREMIUM BENEFIT AUTHORIZATION FORM



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
HEALTH INSURANCE PREMIUM BENEFIT
AUTHORIZATION

COMPLETE AND SEND TO THE ASRS
 VIA EMPLOYER SECURE MESSAGING
 www.asrs.gov

Disclosure of member's Social Security number is mandated by Section 6109 of the Internal Revenue Code. The ASRS will use Social Security numbers only to obtain information about an individual's ASRS account and to inform the Internal Revenue Service of distributions and withholdings with respect to the individual's account.

SECTION 1 – Member Information					
Social Security Number		Member Name (Last)		(First)	(Middle Initial)
Mailing Address				Daytime Telephone Number	
City		State	ZIP	Date of Birth (MM/DD/YYYY)	
SECTION 2 – Status Information					
Indicate participant status (check <input checked="" type="checkbox"/> one):					
<input type="checkbox"/> Arizona State Retirement System Retiree			<input type="checkbox"/> Long Term Disability Plan Participant		
Retirement Effective Date: _____			Disability Effective Date: _____		
SECTION 3 – Information for Coverage					
	Last Name	First Name	Social Security Number	Birth Date (MM/DD/YYYY)	Medicare #
Member					
Dependent					
Dependent					
Dependent					
SECTION 4 – Medical Plan			Section 5 - Dental Plan		
Carrier Name			Carrier Name		
Medical Premium Amount \$			Dental Premium Amount \$		
SECTION 6 – Effective Date Coverage to Begin					
Date (MM/DD/YYYY) _____					
SECTION 7 – To be Completed by the Employer Health Insurance Premium Benefit Specialist					
Employer				Phone Number	
<input type="checkbox"/> By checking this box, I certify that I am the employer representative named below and the information on this form is current and correct. I also understand that typing my name in the Electronic Signature field is the legally binding equivalent to my handwritten signature.				Date	
HI Premium Benefit Specialist Electronic Signature				Email Address	

SECTION 1 – Member Information					
Social Security Number		Member Name (Last)		(First)	(Middle Initial)
Mailing Address				Daytime Telephone Number	
City		State	ZIP	Date of Birth (MM/DD/YYYY)	
SECTION 2 – Status Information					
Indicate participant status (check <input checked="" type="checkbox"/> one):					
<input type="checkbox"/> Arizona State Retirement System Retiree			<input type="checkbox"/> Long Term Disability Plan Participant		
Retirement Effective Date: _____			Disability Effective Date: _____		
SECTION 3 – Information for Coverage					
	Last Name	First Name	Social Security Number	Birth Date (MM/DD/YYYY)	Medicare #
Member					
Dependent					
Dependent					
Dependent					
SECTION 4 – Medical Plan			Section 5 - Dental Plan		
Carrier Name			Carrier Name		
Medical Premium Amount \$			Dental Premium Amount \$		



HEALTH INSURANCE PREMIUM BENEFIT AUTHORIZATION FORM



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
HEALTH INSURANCE PREMIUM BENEFIT
AUTHORIZATION

COMPLETE AND SEND TO THE ASRS
 VIA EMPLOYER SECURE MESSAGING
 www.asrs.gov

Disclosure of member's Social Security number is mandated by Section 6109 of the Internal Revenue Code. The ASRS will use Social Security numbers only to obtain information about an individual's ASRS account and to inform the Internal Revenue Service of distributions and withholdings with respect to the individual's account.

SECTION 1 – Member Information					
Social Security Number		Member Name (Last)		(First)	(Middle Initial)
Mailing Address				Daytime Telephone Number	
City		State	ZIP	Date of Birth (MM/DD/YYYY)	
SECTION 2 – Status Information					
Indicate participant status (check <input checked="" type="checkbox"/> one):					
<input type="checkbox"/> Arizona State Retirement System Retiree			<input type="checkbox"/> Long Term Disability Plan Participant		
Retirement Effective Date: _____			Disability Effective Date: _____		
SECTION 3 – Information for Coverage					
	Last Name	First Name	Social Security Number	Birth Date (MM/DD/YYYY)	Medicare #
Member					
Dependent					
Dependent					
Dependent					
SECTION 4 – Medical Plan			Section 5 – Dental Plan		
Carrier Name			Carrier Name		
Medical Premium Amount \$ _____			Dental Premium Amount \$ _____		
SECTION 6 – Effective Date Coverage to Begin					
Date (MM/DD/YYYY) _____					
SECTION 7 – To be Completed by the Employer Health Insurance Premium Benefit Specialist					
Employer				Phone Number	
<input type="checkbox"/> By checking this box, I certify that I am the employer representative named below and the information on this form is current and correct. I also understand that typing my name in the Electronic Signature field is the legally binding equivalent to my handwritten signature.				Date	
HI Premium Benefit Specialist Electronic Signature				Email Address	

SECTION 6 – Effective Date Coverage to Begin	
Date (MM/DD/YYYY) _____	
SECTION 7 – To be Completed by the Employer Health Insurance Premium Benefit Specialist	
Employer	Phone Number
<input type="checkbox"/> By checking this box, I certify that I am the employer representative named below and the information on this form is current and correct. I also understand that typing my name in the Electronic Signature field is the legally binding equivalent to my handwritten signature.	Date
HI Premium Benefit Specialist Electronic Signature	Email Address

- The premium benefit will not be paid to the employer until after the retirement benefit is calculated or LTD benefits are approved, but it will be paid retroactively based on the effective date listed on the form.
- The HIPB Is paid in full months. If the effective date of coverage is mid-month, the HIPB payment begins on the first of the following month.



HEALTH INSURANCE PREMIUM BENEFIT AUTHORIZATION

SECTION 3 – Information for Coverage					
	Last Name	First Name	Social Security Number	Birth Date (MM/DD/YYYY)	Medicare #
Member					
Dependent					
Dependent					
Dependent					

Common Issues

- Missing information
 - Signature
 - Dependent SSN
 - Member/dependent Medicare number
 - Missing dependent DOB
- Using an outdated form.
- Forms submitted for someone who hasn't retired yet.
- Coverage Elected does not match member/dependent information
 - Example:
 - Single Coverage but there is a dependent listed on the form
 - Family Coverage but there is no dependent listed on the form.



HEALTH INSURANCE PREMIUM BENEFIT AUTHORIZATION

SECTION 4 – Medical Plan	Section 5 - Dental Plan
Carrier Name <input type="text"/>	Carrier Name <input type="text"/>
Medical Premium Amount \$ <input type="text"/>	Dental Premium Amount \$ <input type="text"/>

COMMON ISSUES:

- Carrier Name and Premium do not match information on file with ASRS.
- The member completed the form when the employer should have completed and therefore incorrect information is entered.



EMPLOYER/VENDOR ACH FORM



ARIZONA STATE RETIREMENT SYSTEM
EMPLOYER/VENDOR ACH DIRECT
DEPOSIT FORM

COMPLETE AND SEND TO THE
ASRS VIA EMPLOYER SECURE
MESSAGING
www.asrs.gov

START NEW AUTHORIZATION
 CHANGE EXISTING AUTHORIZATION
 CANCEL EXISTING AUTHORIZATION

This form applies to the following transactions (check all that apply):

Health Insurance Premium Benefit
 Excess Benefit Payments

Other _____

PAYEE IDENTIFICATION

Employer Name _____

Mailing Address _____ Suite / Apt. Number If Needed _____

City _____ State _____ ZIP _____

Business Telephone Number & Extension (_____)
 Employers Identification Number (EIN) _____

AUTHORIZATION FOR SETUP, CHANGES OR CANCELLATION

I hereby authorize the Arizona State Retirement System (ASRS) to deposit payments into the financial institution and account designated below. I recognize that if I fail to provide complete and accurate information on this authorization form, processing of the form may be delayed, or result in erroneous electronic payments.

I further authorize the ASRS and/or this bank to debit the account for the purpose of error corrections from the designated account. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize the ASRS to withhold any payment owed until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to the ASRS. The change or revocation is effective on the day the ASRS processes the request.

I certify that I have read and agree to comply with the ASRS rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or repealed. I consent to, and agree to, comply with these rules even if they conflict with this authorization form.

I certify that I am authorized to contract for the entity receiving deposits pursuant to this agreement, and that all information provided is accurate.

FINANCIAL INSTITUTION INFORMATION

Deposit directly into employers:
 Checking Account
 Savings Account (Check only one)

Banking Institution _____

Routing # _____ Account # _____

NOTE: The routing number is always 9 digits for a U.S. financial institution.

Print Name of Authorized Legal Representative	Title
Payee - Signature of Authorized Legal Representative	Date



HEALTH INSURANCE
PREMIUM BENEFIT
PAYMENTS ARE ISSUED
ON THE 18TH OF EVERY
MONTH



CHANGE/DELETION FORM



**ARIZONA STATE RETIREMENT SYSTEM (ASRS)
HEALTH INSURANCE
CHANGE / DELETION FORM**

COMPLETE AND SEND TO THE ASRS
VIA EMPLOYER SECURE MESSAGING
www.asrs.gov

Disclosure of member's Social Security number is mandated by Section 6109 of the Internal Revenue Code. The ASRS will use Social Security numbers only to obtain information about an individual's ASRS account and to inform the Internal Revenue Service of distributions and withholdings with respect to the individual's account.

SECTION 2 – Change		
<input type="checkbox"/> Change Member Coverage <input type="checkbox"/> Add Dependent Information <input type="checkbox"/> Change Dependent Coverage		<input type="checkbox"/> Change Medicare Status <input type="checkbox"/> Other _____
Old Medical Premium \$ _____		Old Dental Premium \$ _____
New Medical Premium \$ _____		New Dental Premium \$ _____
Effective date _____	Phone Number _____	Employer _____
<input type="checkbox"/> By checking this box, I certify that I am the employer representative named below and the information on this form is current and correct. I also understand that typing my name in the Electronic Signature field is the legally binding equivalent to my handwritten signature.		
HI Premium Benefit Specialist Electronic Signature: _____		Date _____



HEALTH INSURANCE CHANGE/DELETION FORM

COMMON ISSUES:

- Form not submitted within 30 days of the change.
- COBRA coverage has ended
- Dependent has aged out
- Member and/or Spouse has become Medicare Eligible.
- Member has ended their coverage on the employer plan.
- Effective Date for the coverage change or End Date are missing.
- Addresses medical or dental only when the member was set up for both.
- Notification to terminate coverage that was never added.
- Not depositing or returning a premium benefit payment

REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST (SIX-MONTH REIMBURSEMENT PROGRAM)



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
REIMBURSEMENT OF MEDICAL AND/OR DENTAL

PLEASE PRINT

COMPLETE AND
SEND TO:

Phoenix
Tucson (520) 239-
3100
ASRS - Health Ins.



ARIZONA STATE RETIREMENT SYSTEM (ASRS)
REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST

Phoenix: (602) 240-2000
Tucson: (520) 239-3100
Toll Free: (800) 621-1278
www.asrs.gov

Eligible retirees and LTD participants may receive the HIPB through the six-month reimbursement process under the following conditions. The member:

- Is currently receiving a pension or LTD benefit from the ASRS; **AND**
- Has at least five years of credited ASRS service; **AND**
- Has medical and/or dental coverage as a policy holder through an ASRS employer's *active employee* group plan; **OR**
- Has medical and/or dental coverage as a dependent through an ASRS employer's *active employee* group plan; **AND**
- Retired or became disabled before August 2, 2012; **OR**
- Retired or became disabled on or after August 2, 2012, *and* the group plan is *not* subsidized* by the employer; **AND**
- Has out-of-pocket expenses for medical and/or dental premiums.

IMPORTANT NOTES:

Do not use this form for retirees or LTD participants who have medical and/or dental coverage through an ASRS employer's *retiree* group plan or COBRA. Employers must utilize the *Health Insurance Premium Benefit Authorization* form to process the premium benefit for retirees and LTD participants who have coverage through a plan offered to all of the employer's retirees.

Vision, life insurance, disability, or any insurance other than medical and dental is **not** eligible for the HIPB.

Name of Employer	Employer Phone Number ()	E-mail Address
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Reimbursement of Medical and/or Dental Cost Form
Page 1 of 1
Revised: 06/21/2016

REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST (SIX-MONTH REIMBURSEMENT PROGRAM)

SECTION 1 – Retired/LTD Participant Member Information – TO BE COMPLETED BY THE MEMBER			
Social Security Number	Name (Last)	(First)	(Middle Initial)
Mailing Address			Daytime Telephone Number ()
City	State	ZIP	Date of Birth (MM/DD/YYYY)
SECTION 2 – Retired/LTD Participant Member Status Information – TO BE COMPLETED BY THE MEMBER			
A. Indicate member status with the ASRS (check ☐ only one): <input type="checkbox"/> Arizona State Retirement System retiree <input type="checkbox"/> Long Term Disability Plan participant (Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No) NOTE: If the retirement/LTD date is on or after August 2, 2012, you may not be eligible for reimbursement. Please see instructions.		B. Indicate member status with the employer (check ☐ only one): <input type="checkbox"/> Return to work retiree on active employee group plan <input type="checkbox"/> Long Term Disability participant on active employee group plan <input type="checkbox"/> Dependent on active employee group plan	



REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST (SIX-MONTH REIMBURSEMENT PROGRAM)

SECTION 3 – Insurance Coverage Information – TO BE COMPLETED BY THE EMPLOYER					
	Last Name	First Name	Social Security Number	Date of Birth (MM/DD/YYYY)	Effective Date of Coverage (MM/DD/YYYY)
Policy Holder					
Dependent					
Dependent					
Dependent					
SECTION 4 – Six-Month Reimbursement Totals (Jan. to June OR July to Dec.) – TO BE COMPLETED BY THE EMPLOYER					
Date (List each MM/YYYY)	Total Medical Plan Premium Per Month	Total Dental Plan Premium Per Month	Employee Out-of-Pocket* Medical Premium Per Month	Employee Out-of-Pocket* Dental Premium Per Month	Total Employee Monthly Out-of-Pocket* Premium Per Month
Total					\$
SECTION 5 – Employer Representative Information – TO BE COMPLETED BY THE EMPLOYER					
Name of Employer		Employer Phone Number ()		E-mail Address	



REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST (SIX-MONTH REIMBURSEMENT PROGRAM)

Reimbursements are for six-month periods only (January through June OR July through December).

Claims for reimbursement must be submitted for each six-month period and within 60 days after the six-month period ends.

Reimbursement will be the lesser of either the eligible premium benefit amount or the out-of-pocket expenses.

Reimbursements are paid directly to the retired member or LTD participant.

Claims for reimbursement will be processed within 60 days of receipt of this form.



REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST (SIX-MONTH REIMBURSEMENT PROGRAM)

REMINDERS

- Ensure SSN listed is for the person who is eligible for the premium benefit.
 - Retired/LTD member whose status is indicated in 2B
- Complete Section 2B

SECTION 2 – Retired/LTD Participant Member Status Information – TO BE COMPLETED BY THE MEMBER	
A. Indicate member status with the ASRS (check <input type="checkbox"/> only one): <input type="checkbox"/> Arizona State Retirement System retiree <input type="checkbox"/> Long Term Disability Plan participant (Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No)	B. Indicate member status with the employer (check <input type="checkbox"/> only one): <input type="checkbox"/> Return to work retiree on active employee group plan <input type="checkbox"/> Long Term Disability participant on active employee group plan <input type="checkbox"/> Dependent on active employee group plan

NOTE: If the retirement/LTD date is on or after August 2, 2012, you may not be eligible for reimbursement. Please see instructions.

- The form should be for January–June or July–December.
 - Including 2 time frames on the form will cause it to be rejected. Or an ESM will be sent for clarification.

OTHER OPERATIONS

Other Operations <

- Leave of Absence
- Forms & Packets**
- Ending Payroll Verification
- Review Return To Work Forms
- Maintain Employer Users
- Maintain Employer Contacts
- Check Member Eligibility
- Reports**
- Employer Users Activity Report

Your Account <

- Home Page

Communication & Education <

- Secure Messages
- Employer Tutorials
- Employer Meeting Registration

Other Operations <

- Forms & Packets
- Check Member Eligibility
- Reports

Your Profile <

- View Profile
- Change Password

Log Out

Reports

This page will allow you access to secure reports

HI Premium Benefit Report for May
Click here to <input type="button" value="Download Report"/>
HI Premium Benefit Report for April
Click here to <input type="button" value="Download Report"/>
HI Premium Benefit Report for March
Click here to <input type="button" value="Download Report"/>

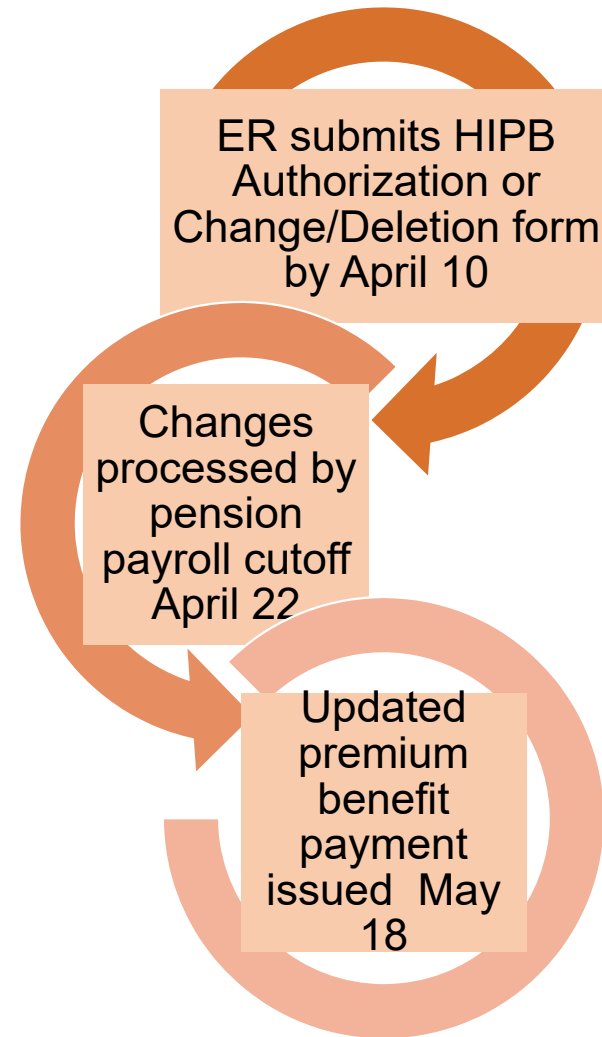
MONTHLY RECONCILIATION REPORT

Also known as the 460 Report or HIPB Payroll Summary

		Employer Summary Sheet						
		PREMIUM		PREMIUM BENEFIT		MEMBER COST		
Carrier Acc DP/NDP		DP	NDP	DP	NDP	DP	NDP	Payroll Month
1022	Monthly Transactions							
DP	RET	LTD	0.00	0.00	0.00	0.00	0.00	
		RETIRE	904.50	0.00	237.38	0.00	667.12	
		NEWRET	0.00	0.00	0.00	0.00	0.00	
		SVRBRT	0.00	0.00	0.00	0.00	0.00	
Carrier 1022		NONE	0.00	0.00	0.00	0.00	0.00	
	Adjustments							
		LTD	0.00	0.00	0.00	0.00	0.00	
		RETIRE(OLD)	0.00	0.00	0.00	0.00	0.00	
		RETIRE(NEW)	0.00	0.00	0.00	0.00	0.00	
		NEWRET(OLD)	0.00	0.00	0.00	0.00	0.00	
		NEWRET(NEW)	0.00	0.00	0.00	0.00	0.00	
		SVRBRT(OLD)	0.00	0.00	0.00	0.00	0.00	
		SVRBRT(NEW)	0.00	0.00	0.00	0.00	0.00	
		MANUAL	0.00	0.00	0.00	0.00	0.00	
	Grand Totals :		904.50	0.00	237.38	0.00	667.12	0.00
	WARRANT AMOUNT :		237.38		FORMULA FOR WARRANT AMOUNT: (237.38 + 0.00)			

REMINDERS

- Review the report every month
- For changes to be reflected in the following month's payment, submit HIPB Authorization or Change/Deletion forms by the 10th of the month.



STAY IN COMPLIANCE

Use your monthly reconciliation report to verify your participants and plans from the ending plan year.

- Identify participants who are no longer on your plan
 - A participant who is Medicare Eligible (65+) but is still on a Non-Medicare Plan
 - A participant who has dropped the employer coverage
 - A participant who was on COBRA but the coverage has ended.
- Identify participants who may be on the wrong plan type (qualifying event)
 - Has a deceased dependent but plan type is still for Member and Spouse when it should be Member only.
 - Dependent who has aged out at 26
 - Participant or spouse who are now both Medicare eligible but are still on a combination plan (Medicare + non-Medicare)

Please remember to submit a Change/Deletion form for any participants identified.

QUESTIONS?