ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2018 Benefit Options Enrollment Form – COBRA

APPLICANT INFORMATION

REQUIRED INFORMATION

Insured Last Name		Insured First Name		Insured MI	
Insured State of AZ EIN (if applicable)	Insured SSN	Insured Sex ☐M ☐F	Insured Date of Birth ___/___/____		
Insured Street Address		Insured City		Insured ST / Insured Zip	Insured County
Insured Home Phone	Insured Cell Phone	Insured Email			
State Employee EIN	State Employee SSN	State Employee Email		State Employee Cell Phone	State Employee Agency

Select all that apply:

- ☐ New Enrollment
- ☐ Adding Dependent(s)
- ☐ Address Change
- ☐ Qualifying Life Event
- ☐ Dropping Dependent(s)
- ☐ Terminate Coverage

QUALIFIED LIFE EVENT*

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Change in Dependent Eligibility Status
- ☐ Gain/Loss of Other Coverage
- ☐ Death of Spouse/Dependent
- ☐ Moved out of plan's service area

Date of Event: ___/___/____

NOTICE

***FOR A QUALIFIED LIFE EVENT: THIS FORM MUST BE SUBMITTED ALONG WITH REQUIRED DOCUMENTATION WITHIN 31 DAYS OF THE QUALIFIED LIFE EVENT.**

SPOUSE/DEPENDENT INFORMATION

ACTION	LAST NAME, FIRST NAME, MI	SSN (REQUIRED)[1]	DATE OF BIRTH	SEX	RELATIONSHIP[2]	MEDICAL (M) DENTAL (D) VISION (V)
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V
☐ Add ☐ Drop				☐ M ☐ F		☐ M ☐ D ☐ V

[2]FOR RELATIONSHIP- YOU MUST MARK **SPOUSE**, **CHILD**, **STEPCHILD**, **PLACED** FOR ADOPTION, OR **GUARDIAN**.

MEDICAL PLANS– PER MONTH PREMIUMS LISTED*

ACTION	PLAN TYPE	PROVIDER	COVERAGE LEVEL	
☐ Enroll ☐ Decline	☐ **NAU** - PPO	☐ Blue Cross Blue Shield of AZ	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Employee & Family	$696.28 $1,462.19 $1,114.05 $2,158.48
☐ Enroll ☐ Decline	☐ **State** - EPO	☐ Aetna ☐ Blue Cross Blue Shield of AZ ☐ Cigna ☐ UnitedHealthcare	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Employee & Family	$676.69 $1,431.64 $956.53 $1,670.18
☐ Enroll ☐ Decline	☐ **State** - PPO	☐ Aetna ☐ Blue Cross Blue Shield of AZ ☐ UnitedHealthcare	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Employee & Family	$756.62 $1,599.11 1,070.22 1,865.77
☐ Enroll ☐ Decline	☐ **State** - HDHP	☐ Aetna	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Employee & Family	$449.82 $953.02 $636.24 $1,111.31

NOTICE

****If you do not select ENROLL or DECLINE for EACH coverage: Medical, Dental, and Vision, THE COVERAGE WILL BE DECLINED AUTOMATICALLY.**

[1]***Social Security Numbers:*** *All active State employees are required to provide Social Security Numbers (SSNs) for their enrolled dependents. The SSN is used as the basis for the Medicare Health insurance claim number (HICN). The HICN identifies Medicare beneficiaries receiving health care services, and assists Medicare in its responsibilities to pay for health care and operate the program. 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 & Accountability Act Privacy Rule (HIPPA). Please note that the Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for benefit coordination.*

ADOA USE ONLY

COBRA EFFECTIVE: ____/____/____ **LENGTH OF COBRA: _____**

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VISION PLAN–PER MONTH PREMIUMS LISTED			
ACTION	**PROVIDER**	**COVERAGE LEVEL**	
□ Enroll □ Decline	□ **State** - Avesis Vision Coverage	□ Employee Only □ Employee + Spouse □ Employee + Child □ Employee & Family	$4.07 $13.20 $13.02 $16.42

DENTAL PLANS– PER MONTH PREMIUMS LISTED			
ACTION	**PROVIDER**	**COVERAGE LEVEL**	
□ Enroll □ Decline	□ **State** - Cigna Dental HMO	□ Employee Only □ Employee + Spouse □ Employee + Child □ Employee & Family	$8.69 $17.38 $16.92 $26.05
□ Enroll □ Decline	□ **State** - Delta Dental PPO Plus Premier	□ Employee Only □ Employee + Spouse □ Employee + Child □ Employee & Family	$36.66 $77.14 $61.69 $120.63

NAU BCBSAZ PPO ONLY

COBRA continuation coverage for the NAU BCBSAZ PPO is administered by NAU Human Resources. COBRA continuation coverage for the State medical plans and all the dental and vision plans is administered separately by ADOA – Benefit Services Division.

- If you enroll in the NAU BCBSAZ PPO you will be sent an invoice from our third party administrator ASI after your enrollment form has been received.
- If you elect to continue coverage for one of the State medical plans or the dental and\or vision plan there are different administrative rules and they are defined below.

FIRST PAYMENT FOR CONTIUATION COVERAGE – STATE PLANS ONLY

- If you elect continuation coverage, you do not need to send payment with the Enrollment Form.
- **Your first payment is due (i.e., must be postmarked) no later than 45 days after the date your Enrollment Form was postmarked (or faxed, or scanned) and sent to ADOA – Benefit Services Division.**
- Keep in mind that your Enrollment Form will not be processed, and your COBRA coverage will not become effective, until payment is made in full. Further, if you fail to make your first payment within the 45 days allotted, you will lose all continuation coverage rights under the Plan.
- If payment is made on time (as indicated above), COBRA continuation coverage will begin the day after your job-based coverage ended.
- You are responsible for making sure that the amount of your first payment is correct.
- You may contact ADOA – Benefit Services Division at (602) 542-5008 or (800) 304-3687 to confirm the correct amount of your first payment.

MONTHLY PAYMENTS FOR CONTIUATION COVERAGE – STATE PLANS ONLY

- After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments thereafter.
- The amount due per month for each qualified beneficiary will be sent to you in a billing statement from ADOA – HITF.
- If you make a full payment on or before the due date, your continuation coverage under the Plan will continue for another month without a break.
- Billing statements are mailed as a courtesy. If you do not receive a bill, you may call ADOA – Benefit Services Division for assistance.

PAYMENTS – WHERE AND HOW TO SEND – STATE PLANS ONLY

All payments for the State of Arizona COBRA plan continuation coverage shall be made by check or money order and made out to: Arizona Department of Administration – HITF	**Send your payments to:** Arizona Department of Administration – Health Insurance Trust Fund (HITF) 100 N. 15th Ave., Suite 302 Phoenix, AZ 85007

EXTENSION OF COBRA COVERAGE – STATE PLANS ONLY

- If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled, or if a second qualifying life event occurs.
- You must notify the ADOA – Benefit Services Division of a disability or a second qualifying life event immediately to extend the period of continuation coverage.
- Failure to provide notice to the ADOA – Benefit Services Division of a disability or second qualifying event may affect your right to extend the period of continuation coverage.
- Please contact Benefit Services for additional information if you have experienced a qualifying life event.

AUTHORIZATION AND SIGNATURE

I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true. I am aware that providing false information - including that which is related to my address, spouse, or dependent(s) - may subject me to denial of health benefits, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of the Affordable Care Act (ACA).

Signature: _____ **Date**: ___/___/____
electronic signatures not accepted

Return by mail, fax or email to: NAU Human Resources PO Box 4113, Flagstaff AZ 86011-4113
Phone: 928.523.2223| hr.contact@nau.edu | Fax: 928.523.7486