MARICOPA COUNTY

RETIREE HEALTH INSURANCE BENEFIT ENROLLMENT/CHANGE FORM

REASON FOR FORM (Check One)

❑ New Retiree	❑ Medicare Eligible	❑ Name Change	❑ Other (explain)
❑ Cancellation	❑ Open Enrollment	❑ Address Change	❑ Change Reason:_____

RETIREE INORMATION (Please Print)

Social Security #	Last Name	First Name	MI	Date of Birth	Married Single

Mailing Address	City	State	Zip Code

Home Phone	Mobile Phone	Email Address

RETIREMENT SYSTEM INFORMATION (Check One)

❑ Arizona State Retirement System	❑ Elected Officials' Retirement Plan
❑ Public Safety Personnel Retirement System	❑ Correction Officer Retirement Plan

MEDICAL PLAN CHOICE

Medical Plans
Check One

- ❑ Health Select
- ❑ CIGNA HMO
- ❑ CIGNA POS
- ❑ CIGNA PPO
- ❑ CIGNA Medicare+Choice*

Level Of Coverage
Check One

- ❑ Retiree Single Under 65
- ❑ Retiree Single Over 65
- ❑ Dependent(s) Under 65
- ❑ Dependent Over 65

Medicare Information
Check if you or your dependent has Medicare. Attach a copy of Medicare card to this completed form.

❑ I have Medicare	❑ My Dependent has Medicare
O Part A	O Part A
O Part B	O Part B

***You must be enrolled in Medicare Parts A & B and reside in Maricopa County to enroll in the CIGNA Medicare+Choice product**. You must complete this form & also contact CIGNA at 1-800-592-9231 to enroll in CIGNA Medicare+Choice.

RETIREE & DEPENDENT COVERAGE INFORMATION (List Retiree and Dependent Information below)

Action	Social Security #	Last Name	First Name	Relationship	Date of Birth	Sex	Provider Name/Number
❑ Add ❑ Drop							
❑ Add ❑ Drop							

COORDINATION OF BENEFIT INFORMATION FOR MEDICAL PLAN

(must provide other non-County insurance coverage information)

Medical Plan Name	Plan Address	Plan Phone Number	I.D.#	Group #	Effective Date

STATEMENT OF UNDERSTANDING

Retirement Date:_____ Length of service with Maricopa County Years:_____ Months:_____

❑ I have read the Statement of Understanding on the reverse side of this form and request enrollment in the Maricopa County Retiree Insurance Benefit Plan as shown above. I certify the answers above to be true and accurate. I hereby authorize the appropriate Retirement System to take deductions from my monthly retirement check for the insurance premium payment.

❑ I withdraw from medical coverage effective _____. By withdrawing, I understand that I am no longer eligible to participate in the medical insurance offered though Maricopa County.

EMPLOYEE SIGNATURE:_____ DATE:_____

SPACE BELOW IS FOR OFFICE USE ONLY

RETIREMENT SYSTEM Employer code:07	MARICOPA COUNTY	
	CIGNA	**HealthSelect**
❑ Maricopa County Rate Code: _____ ❑ Monthly Premium: _____	❑ Retirees (NPRET) ❑ Under 65 (NPRU65 ❑ Over 65 (NPRO65) ❑ HMO (NPRCOM)	❑ Under 65 (PRU) ❑ Over 65 (PRO)
Retirement System Effective Date: Validation:	Maricopa County Effective Date: Validation:	

MARICOPA COUNTY

RETIREE HEALTH INSURANCE BENEFIT ENROLLMENT/CHANGE FORM

INSTRUCTIONS

Please print. Return form and any attachments to the Maricopa County Employee Benefits Office, 301 W. Jefferson, Suite 201, Phoenix AZ 85003.

REASON FOR FORM

Please check the appropriate box indicating your reason are completing this form. If it is because of a change, state the reason in either the Other or the Change Reason area. Examples of changes are marriage, divorce, death or attaining Medicare eligibility. You must submit the form to the Benefits Office within thirty-one (31) days of the date of the change.

If you no longer want coverage, check the "Cancellation" box in the Reason for Form section and check the withdrawal statement in the Statement of Understanding section. Once you have cancelled coverage in the Maricopa County Retiree Health Insurance Benefit Plan, you will not be permitted to re-enroll.

RETIREMENT SYSTEM INFORMATION

Please check the retirement system in which you participate.

MEDICAL PLAN CHOICE

Please choose a medical insurance carrier, product and the level of coverage. If you are enrolling in the CIGNA Medicare+Choice product, please call CIGNA for enrollment information at 1-800-592-9231. You must also complete this form so that your premium payment may be coordinated with your retirement system. You must be enrolled in Medicare Parts A & B and reside in Maricopa County to enroll in this product. If your are enrolling in HealthSelect and or CIGNA HMO, POS or PPO and are Medicare eligible, please send a copy of your and/or your dependents Medicare card.

RETIREE & DEPENDENT COVERAGE INFORMATION

Please list the names of the retiree and all other dependents to be covered or dropped from coverage. Make sure to check the appropriate add or delete box. Indicate your listed dependents' Social Security Number, relationship to you (if you are citing a legal guardianship of a minor child, please attach a copy of the Court documents to this form), date of birth (if child is over the age of 19, please include documentation showing full time student status), gender, and choice of provider.

COORDINATION OF BENEFIT INFORMATION FOR MEDICAL PLAN

If you are covered under another medical insurance plan, provide the name of the insurance plan/company, address, phone number, identification number, group number and the effective date of coverage.

STATEMENT OF UNDERSTANDING

Please read the following statement and check the box indicating that you have done so.

I certify that all of my statements on the form are true. I also authorize deductions from my pension check to cover the premium due for the medical benefit I have chosen. Maricopa County policy requires that your pension benefit be sufficient to cover the cost of your insurance premium in order to maintain eligibility as a participate in the Maricopa County Retiree Medical Plan. The County will not permit coverage in the retiree medical plan on a direct pay basis. If your pension benefit is not sufficient to cover the cost of your coverage, you will be disenrolled from the Maricopa County Retiree Health Insurance Benefit program. Coverage in the Retiree Health Insurance Benefit program will also terminate on the date that Maricopa County no longer offers health care coverage.

BY SIGNING THIS FORM, I ALSO AUTHORIZE ANY PHYSICIAN OR MEDICAL FACILITY TO RELEASE INFORMATION TO MY HEALTH CARE PROVIDERS ABOUT THE CARE OR TREATMENT OF EITHER MY DEPENDENTS OR MYSELF.

Please sign and date the form.

NOTE: Please verify your insurance deduction is withheld on your pension check. If there is an error in your deduction, please contact Employee Benefits at 602-506-1010. If there is a clerical error, the County will correct the administrative error on a no loss, no gain basis.