Maricopa County

Group Insurance Enrollment/Change Form

Employee Information

Please Print

Request Alternative Identification # ❑ Yes ❑ No	Social Security # (must provide)	County Employee Identification #			
Last Name	First Name	MI	Date of Birth	❑ Male ❑ Female	❑ Married ❑ Single
Mailing Address		City	State	Zip Code	
Home Phone	Work Phone &/ or Pager Number	Email Address		Dept. Name	

Reason For Completing Form (check one)

❑ **New Hire**

❑ **Change**

❑ **Other**

- ❑ Unpaid Leave of Absence
- ❑ Address Change
- ❑ Beneficiary Change
- ❑ Other- Write reason in space below. (can include information about self or dependent)

❑ **Open Enrollment**

Add a Dependent
Please Check a Reason

- ❑ Marriage
- ❑ Birth
- ❑ Adoption of child
- ❑ Legal Guardianship of child
- ❑ Qualified medical child support order
- ❑ Other _____

Remove a Dependent
Please Check a Reason

- ❑ Divorce (date of divorce)
- ❑ Legal Separation
- ❑ Death
- ❑ Dependent child reaches limiting age of contract
- ❑ Other_____

Employment Change
Please Check a Reason

- ❑ Change of Spouse s employment
- ❑ Either you or your spouse switched from part-time to full time or vice versa
- ❑ A significant change in your spouse s employer s insurance plan
- ❑ Other_____

Medical Plans

Includes Avesis Vision plan and United Behavioral Health plan.

CIGNA

Includes
Walgreens Health Initiatives (RX)

Plans	FT	PT
❑ HMO	009	P09
❑ POS	007	P07
❑ PPO	010	P10

HealthSelect

Plan	FT	PT
❑ Health Select	004	PO4

Level of Coverage

- ❑ Employee (001)
- ❑ Employee & Spouse (002)
- ❑ Employee & Children (003)
- ❑ Family (004)
- ❑ Decline medical Coverage (999/998)

Dental Plans

- ❑ **Employers Dental Services** (104)
- ❑ **United Concordia Dental** (103)

Level of Coverage

- ❑ Employee (001)
- ❑ Employee & Spouse (002)
- ❑ Employee & Children (003)
- ❑ Family (004)
- ❑ Decline Dental Coverage (110/998)

Coordination of Benefit Information

Must provide information regarding other available (**non-employee Maricopa County**) coverage

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

Employee & Dependent Coverage Information

		Last Name	First Name	DOB	Sex	Social Security #	
❑ Add ❑ Drop		**Employee** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: EDS Dental Provider #:
❑ Add ❑ Drop	❑ Spouse ❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: EDS Dental Provider #:
❑ Add ❑ Drop	❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: EDS Dental Provider #:
❑ Add ❑ Drop	❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: EDS Dental Provider #:
❑ Add ❑ Drop	❑ Child ❑ Student	**Dependent s** Last Name	First Name	DOB	Sex	Social Security #	Medical Provider #: EDS Dental Provider #:

❑ FOR OFFICE USE ONLY

❑ **HRMS (H001)**		❑ **STAR (S002)**		❑ **Non Payroll (NP 003)**	
❑ **CIGNA**	❑ **Health Select**	❑ **CIGNA**	❑ **Health Select**	❑ **CIGNA**	❑ **Health Select**
❑ Active (HACT)	❑ Active (ACH)	❑ Active (SACT)	❑ Active (SAC)	❑ Contract (NPCON)	❑ Contract (PCO)
❑ Public Safety (HPS)	❑ Public Safety (PSH)	❑ Residents (SRES)	❑ Residents (SRE)		
❑ Elected Officials (HEO)	❑ Elected Officials (EOH)	❑ Contract (SCON)	❑ Contract (SCO)		
❑ Contract (HCON)	❑ Contract (COH)				

Effective Date of Coverage:

Validation :

Maricopa County Employee Benefits
301 West Jefferson, Suite 201, Phoenix, Arizona 85003
Phone: 602-506-1010 Fax: 602-506-2354
BenefitsService@mail.maricopa.gov
Revised Sept-02

Basic Life with AD&D 1 X Salary

Unum Life

(Paid by Maricopa County) (401)

Supplemental Life with AD&D

Unum Life

(Paid by employee) (402)

Non-Smoker	Smoker	
❑ 1 X Salary (001) ❑ 2X Salary (002) ❑ 3X Salary (003) ❑ 4X Salary (004) ❑ 5X Salary (005)	❑ 1 X Salary (011) ❑ 2X Salary (012) ❑ 3X Salary (013) ❑ 4X Salary (014) ❑ 5 X Salary (015)	❑ **Decline Supplemental Life**

Life Insurance Beneficiary Information For Basic and Supplemental Life

Examples of types of Beneficiary Designations*

- ✓ Primary- The entire benefit goes to the person(s) listed as primary .
- ✓ Secondary- In the event of the Primary beneficiary s death, the benefit would go to the person(s) listed as secondary
- ✓ Percentages- Must total 100%

***NOTE: Do not* list a dollar amount**

Beneficiary First Name	Beneficiary Last Name	Beneficiary Mailing Address	Date of Birth	Phone Number	Relationship	Benefit Designation*

Dependent Life

Unum Life

(Paid by employee) (403)

❑ Spouse $5,000 & each child $2,500 (001)

❑ Spouse $10,000 & each child $5,000 (002)

❑ **Decline Dependent Life**

Short Term Disability

Unum

(Paid by employee) (301)

❑ 50% (002)

❑ 60% (003)

❑ 70% (004)

❑ **Decline Short Term Disability**

Once your plans go into effect, you must have a Qualified Family Status Change as defined by the IRC Section 125 in order to modify your Medical, Dental or Spending Account plan elections. Information about the IRC section 125 plans can be found online at http://www.maricopa.gov/benefits.

It is the **responsibility** of the employee to submit the change request to the benefits department, by submitting an enrollment/ change form and attaching appropriate 3rd party documentation of the qualifying event within 31 calendar days of a family status change. Retroactive changes will not be allowed unless otherwise required by law.

I authorize payroll deductions(from my paycheck) for the required premiums due for benefits I have chosen. I understand that these rates may be revised periodically.

If there is a clerical error, the County will correct the administrative error on a no-loss, no gain basis between you and the County.

I certify that I have read and agree to abide by the information above.

By submitting my open enrollment request or continuing with my current health care coverage, I understand that I am authorizing Maricopa County, and my health care providers, which could include, CIGNA, HealthSelect, Walgreens Health Initiative (WHI), United Behavioral Health (UBH), United Concordia, Employers Dental Service (EDS), UnumProvident, AVESIS and the Mariflex (FSA) administrator, to share medical information and administrative information concerning myself and my dependents. This information will not, however, be shared with any persons not necessary to the delivery of my health care benefits with Maricopa County. I also release Maricopa County and Maricopa County's health care providers from any liability for any good faith release of information pursuant to this authorization.

Employee s Signature : **Date:**