



Arizona Public Employers Health Pool MID-YEAR CHANGE FORM

Employer: **TOWN OF PAYSON**

Change Effective Date: _____

SECTION A: CHANGES

- | | |
|---|--|
| <input type="checkbox"/> Update Address
<input type="checkbox"/> Marriage
<input type="checkbox"/> Death of Dependent
<input type="checkbox"/> Voluntary Termination of Benefits
<input type="checkbox"/> Other | <input type="checkbox"/> Update Coverage Elected
<input type="checkbox"/> Divorce/Legal Separation
<input type="checkbox"/> Late Notification of Lost Dependent Status
<input type="checkbox"/> Add Dependents (Please include necessary paperwork)
<input type="checkbox"/> Birth/Adoption
<input type="checkbox"/> Medicare/Medicaid Entitlement
<input type="checkbox"/> USERRA
<input type="checkbox"/> Delete Dependents
<input type="checkbox"/> Loss of Dependent Status
<input type="checkbox"/> Administrative Error
(please explain) |
|---|--|

SECTION B: PLAN OPTION

Employee and any Dependents must ALL elect the same Plan Option if enrolling in medical coverage.
 Plan Selected HDHP w/HSA* HDHP w/HSA* Basic Life Only
 (\$1,500 Deductible member only) (\$2,500 Deductible member only)
 (\$3,000 Deductible member + 1 or more) (\$5,000 Deductible member + 1 or more)

* Additional enrollment materials will need to be completed. There are FSA limitations if selecting this plan. See your employer for details.

SECTION C: TIER SELECTION

- | | |
|---|--|
| <input type="checkbox"/> Active Employee
<input type="checkbox"/> Medical/RX
<input type="checkbox"/> Dental
<input type="checkbox"/> Vision | <input type="checkbox"/> Retiree
<input type="checkbox"/> Member + Family
<input type="checkbox"/> Member Only
<input type="checkbox"/> Member + Family
<input type="checkbox"/> Member Only
<input type="checkbox"/> Member + Family |
|---|--|

SECTION D: MEMBERSHIP INFORMATION

Employee Last Name _____	First Name _____
Mailing Address _____	Middle Initial _____
City _____ State _____	Social Security # _____

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) _____	Daytime Phone Number _____	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
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SECTION E: DEPENDENT INFORMATION

Have you or your dependents had insurance within the last 62 days? Yes (please provide credible coverage letter) No

Add	Last Name (if different), First, M.I.	Social Security Number	Relationship to Member	Gender	Date of Birth
	(Spouse/Domestic Partner)**			M / F	
	(Child)*			M / F	
	(Child)*			M / F	
	(Child)*			M / F	
	(Child)*			M / F	
	(Child)*			M / F	

Dependents age 26 or older are not eligible to be enrolled for benefits unless disabled.

** A statement of domestic partnership must be completed and submitted with this enrollment form.

SECTION F: COVERAGE UNDER ANOTHER PLAN

Do you or your dependents currently have any other insurance? Yes No If yes Medical Dental (You do not need to indicate coverage.)

List those covered under this plan _____

Name of Insurance Company _____	Policy Holder's Name _____	SSN or plan policy # _____
Insurance Company Address _____	Insurance Company Phone _____	

SECTION G: BENEFICIARY INFORMATION (FOR LIFE INSURANCE BENEFITS)

Beneficiary Designation (Full Name)	Relationship to Member	SSN	Percentage
Mailing Address _____	City _____	State _____	Zip _____
Contingent Beneficiary Designation (Full Name) _____	Relationship to Member _____	SSN _____	Percentage _____
Mailing Address _____	City _____	State _____	Zip _____

READ CAREFULLY:

The group health care benefits available through my employer have been explained to me. I hereby apply for the benefits to which I am entitled and which I have elected on this form. I have reviewed the form to be sure that I have completed all information correctly.

- If I have declined coverage for a family member/Domestic Partner, I understand that this person(s) cannot be enrolled in the Plan unless they are eligible at the next Open Enrollment period or unless there is a qualified special enrollment or a mid-year change of status event.
- I understand that benefits under this Plan are pre-tax. I authorize the deduction of health care premium payments from my before-tax pay that will be applied to the cost of the coverages elected. I understand that the cost of coverage may be changed annually or as announced by my employer.
- I understand that the premiums for domestic partner health benefits may not be paid on a pre-tax basis unless the domestic partner is eligible for tax free health coverage under federal tax laws (e.g., is a tax qualified dependent).
- I understand that the benefits elected must remain in force for the entire Plan Year and that I may not make a change in my coverage or contribution during that Plan Year, unless there is a qualified change in status as defined under the Plan in accordance with Internal Revenue Code regulations.

Authorization to Release Information: For claim purposes, I give my permission to: any physician or medical practitioner; hospital, clinic, pharmacy, insurance company, reinsurer or any other drug organization to give my employer and Arizona Public Employers Health Pool all information on my behalf including findings on medical care, alcohol or drug abuse information, psychiatric care or examination, or surgery, as they apply to me or my dependents who are covered. I know that I have the right to a copy of this authorization. A photocopy will be valid as the original.

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. Misrepresentation of information can result in any of the following: termination of employment, termination of coverage, criminal and/or civil prosecution. I have read the above statements and understand that if I have further benefits questions I should contact my employer's Benefits Office.

Employee Signature: X

SECTION H: FOR HR USE ONLY - DO NOT WRITE BELOW THIS LINE

Date of Hire: _____ Coverage Effective Date: _____

If eligible due to full time status, please note the date of full time employment: _____

Employer Signature: _____ Date: _____