



Arizona Public Employers Health Pool
NEW HIRE/OPEN ENROLLMENT FORM

Employer: \_\_\_\_\_

SECTION A: NEW HIRES/OPEN ENROLLMENT

Form with checkboxes for New Hire, Open Enrollment, Opt Out, and Coverage Selected options (Employee only, Retiree only, Board Member/Council Member only, etc.)

SECTION B: PLAN OPTION

Employees and any Dependents must ALL elect the same Plan Option. Check the Plan Option Desired: Medical/Rx/Dental 5 options - [ ] Core Plan [ ] Copay Plan [ ] Core Plus Plan [ ] HDHP w/HSA\* (\$1,500 Deductible) [ ] HDHP w/HSA\* (\$2,500 Deductible)

SECTION C: MEMBERSHIP INFORMATION

Form with fields for Employee Last Name, First Name, Middle Initial, Vision, Medical, Dental, Mailing Address, Social Security #, City, State, Zip, Gender, Date of Birth, Daytime Phone Number, Marital Status.

SECTION D: DEPENDENT INFORMATION

Form with a table for dependent information including Add, Last Name, Social Security Number, Relationship to Member, Gender, Date of Birth, Vision, Dental, Medical.

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 E: COVERAGE UNDER ANOTHER PLAN

Form with fields for insurance information: Do you or your dependents currently have any other insurance?, 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 F: BENEFICIARY INFORMATION (FOR LIFE INSURANCE BENEFITS)

Form with fields for beneficiary information: 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.

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

Form with fields for Date of Hire, Coverage Effective Date, Employer Signature, Date.