

**PHOENIX ELEMENTARY SCHOOL DISTRICT NO. 1
2018/2019 RETIREE BENEFIT ELECTIONFORM**

1 RETIREE INFORMATION (you must complete all sections of this form)

- Male
 Female
 Single
 Married

Last Name First Name MI Social Security Number

Street Address City, State, ZIP Birth Date

Home Phone Work Phone Email Address

2 ELECT YOUR MEDICAL PLAN (BLUE CROSS BLUE SHIELD)

Select Your Coverage Level

- Retiree Only \$0.00/mo
- Retiree + 1 Dependent \$527.00/mo
- Retiree + Family \$721.99/mo
- Waive (Decline)

Blue Cross Blue Shield of Arizona

Group # 34690
 Member Services Phone Number: 1-855-801-4633
 Website: <https://www.azblue.com>

3 ELECT YOUR DENTAL PLAN (DELTA DENTAL)

Select Your Coverage Level

- Retiree Only \$0.00/mo
- Retiree + 1 Dependent \$36.10/mo
- Retiree + Family \$78.46/mo
- Waive (Decline)

Delta Dental of Arizona

Group # 04693
 Member Services Phone Number: 602-938-3131 or 1-800-352-6132
 Website: <http://www.deltadentalaz.com>

4 ELECT YOUR VISION PLAN (DELTA VISION - EYEMED)

Select Your Coverage Level

- Retiree Only \$5.96/mo
- Retiree + 1 Dependent \$12.05/mo
- Retiree + Family \$21.13/mo
- Waive (Decline)

Delta Vision - EyeMed Vision Care Program

Group # 9688037
 Member Services Phone Number: 866-559-5252
 Website: <http://www.eyemedvisioncare.com>

5 ADD COVERAGE FOR YOUR DEPENDENTS

Complete the information below if you want to add medical, dental and/or vision coverage for your eligible dependents

Relationship	Name (First, MI, Last)	Social Security Number	Gender (M/F)	Birthdate (MM/DD/YYYY)	Medical (Check box to add coverage)	Dental (Check box to add coverage)	Vision (Check box to add coverage)
					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
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6 SIGNATURE ACKNOWLEDGEMENT & AUTHORIZATION

By signing below, I acknowledge and agree to the following:

- I have received the required disclosure packet, including my rights under HIPAA and COBRA, along with the appropriate plan summaries.
- Disclosures and Plan Summaries available at <https://phxschools.org/careers/benefits-documentation/>. Please contact Laura in the Benefits Department (602-257-6075 laura.lopez-gomez@phxschools.org) for printed copies.
- I authorize the District to make the necessary deductions from my pay to cover my cost of the above elections, if currently employed by the District full-time.
- The Dependents listed above for enrollment are qualified for coverage under the rules of the plan and I will provide the District with proof upon request.
- I understand that I cannot change my elections outside of the annual Open Enrollment period unless I experience a qualified life status change. In the event I experience a qualified life status change, I may change my elections under the Group's Cafeteria Plan within 31 days of the event. My new elections must be consistent with the life status change. Qualified life status changes are defined in the *Benefits Guide*.
- I will not be "rolled over" into any benefits at Open Enrollment for the 2018-2019 school year, with current elections/coverage terminating June 30, 2018.
- This completed form is due to the benefits office by 5:00 pm on 5/31/2018, or I will forfeit coverage starting July 1, 2018, with no opportunity to re-enroll until July 1, 2019.
- I understand that I will be removed from these selections the first of the month in which I reach 65 years of age and/or become Medicare eligible.
- If I have elected to waive (decline) medical insurance for myself or Dependents, I agree to the following:
 I have been given an opportunity to apply for the medical insurance offered by my employer, for which I am eligible, and decided not to accept the offer for coverage because I have other medical coverage to satisfy ACA requirements.
 I understand that my election to waive group insurance coverage excludes me from receiving any of the District contribution.
 I have read and understand the above statements and will provide the District with proof of my other medical coverage on request.

Retiree Signature

Date