PHOENIX ELEMENTARY SCHOOL DISTRICT NO. 1
2020/2021 COBRA BENEFIT ELECTION FORM

1 FORMER EMPLOYEE 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

- ❑ Former Employee Only $570.82/mo (plus 2% admin fee)
- ❑ Former Employee + 1 Dependent $1,141.64/mo (plus 2% admin fee)
- ❑ Former Employee + Family $1,352.85/mo (plus 2% admin fee)
- ❑ 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

- ❑ Former Employee Only $34.66/mo (plus 2% admin fee)
- ❑ Former Employee + 1 Dependent $72.35/mo (plus 2% admin fee)
- ❑ Former Employee + Family $116.64/mo (plus 2% admin fee)
- ❑ 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

- ❑ Former Employee Only $5.96/mo (plus 2% admin fee)
- ❑ Former Employee + 1 Dependent $12.05/mo (plus 2% admin fee)
- ❑ Former Employee + Family $21.13/mo (plus 2% admin fee)
- ❑ 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)
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop
					❑ Add ❑ Drop	❑ Add ❑ Drop	❑ Add ❑ Drop

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 Lopez in the Benefits Office (602-257-6075 or laura.lopez-gomez@phxschools.org) for printed copies.
- 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 2020-2021 school year, with current elections/coverage terminating June 30, 2020.
- This completed form is due to the Benefits Office by 5:00 pm on 5/31/2020, or I will forfeit coverage starting July 1, 2020.
- 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.
- I understand that I may be removed from these selections if any premiums due are not received by the COBRA Administrator, BASIC, on their due date.
- 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.

Former Employee Signature | **Date**