



# ADMINISTRATIVE PROCEDURES

Procedure Number: 23-22

Effective Date: 11/30/2003

Revision Date: 10/03/2012

*C. Dulubany*  
County Administrator

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**SUBJECT: HEALTH AND LIFE INSURANCE ENROLLMENT PROCESS**

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**DEPARTMENT RESPONSIBLE: Human Resources Department**

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## **I. STATEMENT**

To state the procedures and requirements of insurance enrollments.

## **II. DEFINITIONS**

- A. Eligible employee – A regular full-time or part-time employee who is scheduled to work twenty (20) or more hours per week or forty (40) hours per pay period. A variable-time employee must be scheduled to work for twenty (20) or more hours per week or forty (40) hours per pay period in order to be eligible (Personnel Policy 8-122.B.1).
- B. Eligible dependent – A legally married spouse, domestic partner, natural born child, step-child, child of an insured domestic partner, adopted child, child placed for adoption with the employee and for whom the application and approval procedures for adoption pursuant to A.R.S. §8-108 and §8-108 have begun, and/or a child for whom the employee has obtained court ordered guardianship (Personnel Policy 8-122-B.2). In order to insure a domestic partner and his/her children, the employee must complete an affidavit of Domestic Partnership (Attachment B) each year.
- C. Dependent child – “an eligible child is insurable up to the age of twenty-six (26), regardless of the child’s student or marital status or availability of other employer-based coverage, providing the employee supplies documentation to support the relationship (such as a birth certificate or court order). An enrolled dependent child will continue to be eligible beyond age twenty-six (26) provided he/she is incapable of self-sustaining employment by reason of intellectual or physical disability and is chiefly dependent upon the employee or enrolled domestic partner for support and maintenance. Restrictions may be placed on dependent coverage by an insurance carrier if the dependent is not living within the carrier’s defined service area. At any time, an employee may be requested to document dependent status” (See Personnel Policy 8-122.B.3).
- D. Initial enrollment – For eligible employees who are newly hired, insurance coverage becomes effective the first day of the month following completion of thirty (30) calendar days of eligibility.

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- E. Open enrollment – On an annual basis eligible employees have the opportunity to enroll, change or cancel their medical/dental insurance plans for themselves and/or eligible dependents. Eligible employees also have the opportunity to enroll for additional supplemental life insurance (with restrictions). The employee may elect supplemental life insurance where none had been elected before, increase his/her level of coverage, and/or add dependent life insurance. A Medical History Statement, or Evidence of Insurance (EOI), (Attachment A) may be required by the life insurance company. This form is available on the Pima County Benefits website.
  - F. Qualifying Life Event or Family Status Change – Changes must be made within thirty-one (31) calendar days of the date of occurrence of a family status change as defined in Personnel Policy 8-122.E.1.

### **III. PROCEDURES**

- A. Employees will log on to the Benefits online enrollment system to enroll in or change benefits. Supporting documentation is required to insure dependents and to substantiate family status changes.
- B. New or current employees with an employment status change must submit enrollment via the Benefits online enrollment system. The eligible employee must include all family members he/she wishes to be enrolled. Family members not included will not be covered and may not be added until the next open enrollment period. All enrollments must be received in Human Resources within thirty-one (31) days of eligibility.
- C. Open Enrollment communications will be through numerous methods, including, but not limited to mail, emails, flyers, the Pima County website, Departmental Benefits Representatives and Employee Newsletter articles.
- D. Qualifying Life Events or Family Status Changes enable employees who have an employment or a family status change to amend their benefits coverage via the Benefits online enrollment system to reflect those changes within thirty-one (31) calendar days of the event. Electronic enrollment without appropriate documentation will not be processed and may jeopardize enrollment. Documentation examples required for the qualifying events include, but are not limited to the following:
  - 1. Marriage Certificates or Affidavit of Domestic Partnership (Attachment B).
  - 2. Court ordered separation, divorce or annulment. An application for divorce or a “Minute Entry” are not acceptable documents.
  - 3. Termination of Domestic Partnership (Attachment C).
  - 4. Birth certificate, court document notification of guardianship, adoption or placement for adoption of a child, or a Qualified Medical Child Support Order.
  - 5. Death Certificate.

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6. Dependent's enrollment form in another insurance plan.
  7. Dependent's notice of discontinuation of his/her insurance, COBRA notification, termination of employment with subsequent loss of insurance.
  8. Written notification that the child no longer meets definition of dependent.
  9. Written notification that the child once again meets definition of dependent.
  10. Electronic enrollments indicating beginning or ending a leave of absence.
- E. Enrollments must be made by the following dates:
1. New Hires or Initial Enrollment – within thirty-one (31) days after the date of hire or at the time of insurance eligibility.
  2. Qualifying Life Events – within thirty-one (31) calendar days after the date of the family status change.
- F. Deductions: Paycheck deductions are the payday pursuant of the effective date of coverage. Refer to the Pima County Benefits Effective Date Chart to identify the pay dates.
- G. Employees share the responsibility with Human Resources Benefits to ensure the benefit premiums being deducted from their paycheck are accurate. Employees are responsible for notifying Human Resources Benefits when an error has occurred.

**NOTE:** Whenever Human Resources Benefits becomes aware of a discrepancy in the level of coverage elected and the level of premium being paid by the employee and/or County, Human Resources Benefits shall make the correction retroactive to the date the error occurred. Adjustments can only occur retroactive to the beginning of the current fiscal year. No adjustments are allowed for prior fiscal years. If the employee has been charged an amount greater than the premium owed, the employee will be refunded all extra money received. If the employee has been charged an amount less than the premium owed, the employee will have the difference deducted in the paycheck following reconciliation.

Humana EOI Cover page

Employee Name: \_\_\_\_\_  
Humana Group Number 561416

If there are questions regarding your application

Best phone number to contact you: \_\_\_\_\_

If you would prefer contact via email: \_\_\_\_\_

If you are covering dependents please provide:

Spouse name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____
Child name _____	Date of Birth ____/____/____

Email OR fax this form with the Humana EOI form to:

Email: [PimaEOI@humana.com](mailto:PimaEOI@humana.com)  
Fax: 1-888-235-3260

Group number: **561416** Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Evidence of Health Status					
Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Disabled? If yes, indicate reason.	SSN #
Employee		/		<input type="radio"/> N Reason: <input type="radio"/> Y	
Spouse		/		<input type="radio"/> N Reason: <input type="radio"/> Y	
Child		/		<input type="radio"/> N Reason: <input type="radio"/> Y	
Child		/		<input type="radio"/> N Reason: <input type="radio"/> Y	
Child		/		<input type="radio"/> N Reason: <input type="radio"/> Y	
Other (specify):		/		<input type="radio"/> N Reason: <input type="radio"/> Y	

**This information should not be submitted more than 60 days prior to the effective date.**  
Complete this section for applicants requesting Life insurance over the guarantee issue amount and all late enrollees applying for Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications?  N  Y

2. Within the past 5 years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:

<b>a</b> Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	<input type="radio"/> N <input type="radio"/> Y	<b>f</b> Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y
<b>b</b> Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	<input type="radio"/> N <input type="radio"/> Y	<b>g</b> Stomach, gall bladder, intestinal or colon disorders?	<input type="radio"/> N <input type="radio"/> Y
<b>c</b> Asthma or other disease of lungs or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y	<b>h</b> Rheumatoid arthritis or back disorders?	<input type="radio"/> N <input type="radio"/> Y
<b>d</b> Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	<input type="radio"/> N <input type="radio"/> Y	<b>i</b> Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y
<b>e</b> Cancer, and/or cancerous tumor? (state type & part of body in details section below)	<input type="radio"/> N <input type="radio"/> Y	<b>j</b> Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	<input type="radio"/> N <input type="radio"/> Y

3. Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?  N  Y

4. During the past 5 years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned?  N  Y

5. Are you or any dependent to be covered pregnant?  N  Y

**If you answered "yes" to any of the questions above, please provide details below and specify the question #.**  
**Attach additional signed and dated sheets if necessary.**

Question # & letter	Person treated (Last name, First name)	
Condition	Treatments received	
Medications prescribed	Current or future treatments or medications	
Date diagnosed ___ / ___ / ____	Date last seen by a doctor ___ / ___ / ____	
Question # & letter	Person treated (Last name, First name)	
Condition	Treatments received	
Medications prescribed	Current or future treatments or medications	
Date diagnosed ___ / ___ / ____	Date last seen by a doctor ___ / ___ / ____	

**Signature - please sign below if enrolling or waiving group coverage.**

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and relationship of legal representative: \_\_\_\_\_

Spouse signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Only if selecting Life coverage over the guarantee issue amount.)

Attachment B

**PIMA COUNTY  
AFFIDAVIT OF DOMESTIC PARTNERSHIP**

**SECTION I**

I, \_\_\_\_\_, certify that:  
Name of Employee (Print)

\_\_\_\_\_ and I are domestic partners and have been domestic partners since  
Name of Domestic Partner (Print)

\_\_\_\_\_, and we:  
Date of Partnership

1. share the same permanent residence, **AND**
2. have a close personal relationship, **AND**
3. are jointly responsible for basic living expenses, **AND**
4. are single or divorced, **AND**
5. are eighteen (18) years of age or older, **AND**
6. are not related by blood, **AND**
7. are each other's sole domestic partner and are responsible for each other's common welfare.

**SECTION II**

A. I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change of circumstance attested to in this affidavit.

I agree to notify my benefits/personnel representative if there is any change of circumstances attested to in this affidavit within thirty (30) days of change by filing a Statement of Termination of Domestic Partnership.

B. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed until ninety (90) days after a Statement of Termination of Domestic Partnership has been filed with my benefits/personnel representative, unless such termination is due to the death of my domestic partner.

C. I understand that this Affidavit expires at the end of each plan year and that I will have to sign a new Affidavit during the open enrollment period of each new plan year in order to continue insurance coverage for my domestic partner and/or my domestic partner's dependent(s).

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

State of \_\_\_\_\_

} ss

County of \_\_\_\_\_

Subscribed and sworn (affirmed) before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

My Commission expires:

\_\_\_\_\_  
Notary Public [SEAL.]

**BENEFITS/PERSONNEL REPRESENTATIVE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

Attachment C

**PIMA COUNTY  
STATEMENT OF TERMINATION OF  
DOMESTIC PARTNERSHIP**

I, \_\_\_\_\_, affirm, under penalty of perjury, that the  
Name of Employee (Print)  
Affidavit of Domestic Partnership attested to and signed by me on \_\_\_\_\_  
Date of Affidavit  
shall be and is terminated as of this date: \_\_\_\_\_.

Termination of the Affidavit of Domestic Partnership is due to:

- Termination of Domestic Partnership
- Death of Domestic Partner

I understand that another Affidavit of Domestic Partnership cannot be filed until ninety (90) days after this Statement of Termination of Domestic Partnership has been filed with my departmental insurance/personnel representative, unless termination of the Affidavit is due to death of my domestic partner.

I shall mail a copy of this signed statement to my surviving former domestic partner.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

BENEFITS / PERSONNEL REPRESENTATIVE: \_\_\_\_\_ PHONE: \_\_\_\_\_