



Type or print clearly in black or blue ink. No White Out. Fill out the form completely.

NEW (INITIAL) ENROLLMENT OPEN ENROLLMENT CHANGE CANCEL REASON: _____

ADDITIONS: Newborn Child(ren) Spouse Domestic Partner (D.P.) Other: _____

DELETIONS: Child(ren) Spouse Domestic Partner

CHANGES: Medical Dental Address Change Name Change - **FORMER NAME:** _____

Employee Name (Last, First, M.I.)			E.I.N.	Social Security Number	Male <input type="checkbox"/> Female <input type="checkbox"/>	Birth Date	Single <input type="checkbox"/> Married <input type="checkbox"/>
Address				City	State	Zip Code	Home Phone
Hi Org	Hire Date	Hrs/Pay Period	Department	Job Title			Work Phone

DEPENDENT COVERAGE: Include **ALL** dependents covered. If a child is your domestic partner's, x both boxes - Child and D.P

Dependent's Name (Last, First, M.I.)	RELATIONSHIP			Gender		Soc. Sec. No.	Birth Date	Coverage	
	Spouse	Child	D.P.	Male	Female			Medical	Dental
	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>				

MEDICAL COMPANY NAME: Place name of plan selected here →

HR Use Only	EMPLOYEE ONLY <input type="checkbox"/>	EMPLOYEE & SPOUSE (or D.P.) <input type="checkbox"/>	EMPLOYEE & CHILDREN <input type="checkbox"/>	EMPLOYEE & FAMILY <input type="checkbox"/>	DECLINE COVERAGE <input type="checkbox"/>
	Primary Care Physician and Provider Number: _____ Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No				Eff. Date:
Is a Physician Selection form attached listing the different providers for your dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No					

DENTAL COMPANY NAME: Place name of plan selected here →

HR Use Only	EMPLOYEE ONLY <input type="checkbox"/>	EMPLOYEE & SPOUSE (or D.P.) <input type="checkbox"/>	EMPLOYEE & CHILDREN <input type="checkbox"/>	EMPLOYEE & FAMILY <input type="checkbox"/>	DECLINE COVERAGE <input type="checkbox"/>
	Dentist/Dental Facility and Provider Number: _____ Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No				Eff. Date:

PREMIUM PAYMENT PLAN: I elect to pay my portion of insurance with: **Pre-tax Dollars** **Post-tax Dollars**

COORDINATION OF BENEFITS INFORMATION: Will you and/or your dependents be covered under any other medical and/or dental insurance plan (including Medicare or AHCCCS) while covered with the plans selected above? YES NO

If yes, complete the following: Group Name: _____ Group Number: _____

Company Name & Address: _____ Insured Name(s): _____

Rec'd. Time Stamp

HR USE ONLY

Coded:

Copied:

Entered:

STATEMENT OF UNDERSTANDING:

I certify that all of the above information is correct. I understand that if I pay my portion of my insurance coverage on a pre-tax basis I cannot deduct this on future tax returns. I may change insurance plans only during open enrollment unless I have a qualifying event and make my change within thirty-one (31) calendar days. I may elect to continue my insurance coverage under COBRA upon termination of my employment from Pima County.

Employee

Signature: _____ **Date:** _____

PIMA COUNTY
INSURANCE ENROLLMENT FORM
INSTRUCTIONS

1. Type or print clearly in black or blue ink only. Forms with handwriting that cannot be read will delay processing by both Pima County and the plan providers. Incomplete forms will be returned.
2. Check the appropriate box to indicate the reason for the insurance enrollment form, whether it is a new enrollment, an open enrollment change, a qualifying event change, or a cancellation. If you check change, also indicate the reason for the change in brief terms, i.e., marriage, divorce, birth, adoption, over age child, etc. For a cancellation, indicate if the reason is for termination, retirement or a leave of absence.
3. As appropriate, check the box of the dependent that is to be added or deleted from your policy. If you check the "other" box, identify the relationship of the dependent to you, i.e., child for whom you have legal guardianship, domestic partner's child(ren), etc. See Personnel Policy 8-122 for definition of a dependent.
4. If any of the above changes impact your insurance coverage, identify by checking the box(es) of the coverage type being affected, i.e., medical and/or dental. If you are also choosing to change your name, check the box and write your former name in the space provided.
5. Changes to your policy that occur after you are newly hired or are not during the open enrollment period must be requested within thirty-one (31) calendar days of the qualifying event. Qualifying event changes that require documentation to be attached include the following: marriage, affidavit of domestic partnership, divorce, legal separation, termination of domestic partnership, legal guardianship of a child, deletion of dependent because he/she obtained other insurance or has moved out of the area.
6. Complete information for all dependents on your policy. If you are adding a dependent, be sure to include information on any and all dependents currently on your policy. Place a check in the box to identify the relationship of the person to you as well as the gender of that person. Select the coverage for the dependent, i.e., medical and/or dental.
7. Identify the name of the medical plan and the dental plan that you are choosing in the spaces available. Check the box of the level of coverage that you want and be sure that this box is consistent with the coverage you have selected in the dependents section above.
8. Identify your Primary Care Physician and their identification number and your Dentist and/or Facility in the spaces available. Check the appropriate box if you are or are not a current patient. If you choose to have different Primary Care Physicians for your family members, attach a completed Physician Selection form. Note; pediatricians may serve as your child's Primary Care Physician.
9. Identify if you choose to have your health insurance premiums deducted on a pre-tax or post-tax basis. For further information, please consult your accountant or tax preparer. *(Note: The amount the County pays toward your domestic partner's insurance is considered taxable income and will appear on each pay check. Additionally, the amount of the deduction which is the difference in premium between your domestic relationship coverage and your previous coverage will be deducted on a post-tax basis only)*
10. If you and/or your dependents have health insurance with another provider (such as a spouse's coverage under another employer) and you intend to continue to be covered on that policy, you must complete this section and provide the information requested.
11. Review the Statement of Understanding. Contact Human Resources – Benefits if you have any questions. Sign and date your insurance enrollment form.
12. You must turn in your completed form to your departmental insurance representative. If you do not know who that is, please contact Human Resources – Benefits at 724-8464.
13. After coding and verifying, Human Resources - Benefits staff will send copies to the appropriate providers and to the employee's departmental insurance representative for distribution.