2021 Benefits Enrollment/Change form

Instructions

Step 1: Complete the form fully and legibly

1. If you have more dependents than form space allows, attach an additional page.
2. If evidence of good health and underwriting approval are required for ASU Life and AD&D, Securian will mail a form and instructions to you.
3. Complete and submit the form even if you are waiving all coverage options.
4. Incomplete submissions may delay processing and result in retroactive deductions.

Step 2: Required documents

1. If changing benefits due to a qualified life event, you must provide documentation that supports your changes. Learn more: cfo.asu.edu/qualified-life-events
2. If enrolling a spouse or eligible dependents:
   a. You must provide documentation that demonstrates eligibility, including but not limited to: marriage certificate, birth certificate or passport.
   b. Social Security numbers (SSNs) are required for dependents enrolled in medical, dental and/or vision. If your dependent is not eligible for a SSN due to their visa status, you must provide substantiating documentation, including but not limited to: a legal document showing visa status.
   c. Dependent names and SSNs must match their Social Security card. The IRS may assess a $50 penalty for incorrect dependent data.
   d. Learn more at cfo.asu.edu/eligibility-and-enrollment.
3. All required documentation must be translated to English.

Important: Do not delay submitting this form Benefits Enrollment/Change form if you are waiting to receive required supporting documentation.

Step 3: Submit your completed, signed form within 30 calendar days of hire date, eligibility date or qualified life event effective date

Submit the completed, signed form (pages 2-5 only) and any required documentation by one of the following secure methods:

1. **Fax to:** Confidential Benefits E-fax 480-993-0007
2. **Email to:** HumanResources-Benefits@exchange.asu.edu
   - You must use your ASU email account (asu.edu).
   - You must type [SECURE] in the subject line, including the square brackets.
   - Do not forward or copy others on the email.
   - This box does not send replies or responses to inquiries.
3. **Mail to:**
   Arizona State University
   Attn: Benefits
   P.O. Box 871304
   Tempe, AZ 85287-1304

Step 4: Verify your coverage

1. Log into My ASU using your ASURITE user ID and password.
   a. Go to My Employment > Benefits > My Benefits Summary.
   b. Change the effective date to your coverage effective date and click "Go."
2. For coverage effective date information, visit cfo.asu.edu/benefits-and-mandatory-retirement-effective-dates.
3. For pay period start dates, view Payroll and Payday Calendars at cfo.asu.edu/payroll-calendars.
4. Health care ID cards will be mailed to your home within 2-3 weeks after your enrollments are processed.
5. Report all discrepancies immediately to the Office of Human Resources Employee Service Center at 855-278-5081 or HRESC@asu.edu.

Additional information

- Learn about your benefits options at cfo.asu.edu/benefits
- If your covered dependents are employed by ASU, The University of Arizona, Northern Arizona University, the Arizona Board of Regents or the State of Arizona, you and your dependents can only be covered on the same plans with one employer. **Dual coverage is prohibited.**
- Plan provisions may require that you are actively at work on the effective date of coverage. Learn more: cfo.asu.edu/benefits-and-mandatory-retirement-effective-dates

Need assistance? Office of Human Resources Employee Service Center | 855-ASU-5081 (855-278-5081) | HRESC@asu.edu

Disclaimer: The information contained in this form is provided to allow you to make benefit elections. If there are any discrepancies between this information and official documents, official documents will govern. The State of Arizona, Arizona Board of Regents and Arizona State University reserve the right to modify any of its plans, in whole or part, at any time.

Fax pages 2-5 to 480-993-0007; keep page 1 for future reference.

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Section A: Employee Identification Information

Last Name, First Name, M.I.:	Gender: ☐ Male ☐ Female	Birth Date:	Hire/Eligibility Date:
SSN (Required):	ASU Employee ID (10 Digit):		☐ Single ☐ Married
Street Address, City, State, Zip Code:			
Work Phone:	Home Phone:	Email Address:	

Section B: Dependent Information (Attach separate sheet for additional dependents if applicable)

#					Check one:
1	Last Name, First Name, M.I. as it appears on Social Security card:	Birth Date:	Gender: ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	☐ Add ☐ Remove
	SSN (Required):	ASU Employee ID (10 Digit):			
	Relationship (check one): ☐ Spouse ☐ Child		Select Plan(s): ☐ Medical ☐ Dental ☐ Vision		
2	Last Name, First Name, M.I. as it appears on Social Security card:	Birth Date:	Gender: ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	☐ Add ☐ Remove
	SSN (Required):	ASU Employee ID (10 Digit):			
	Relationship (check one): ☐ Spouse ☐ Child		Select Plan(s): ☐ Medical ☐ Dental ☐ Vision		
3	Last Name, First Name, M.I. as it appears on Social Security card:	Birth Date:	Gender: ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	☐ Add ☐ Remove
	SSN (Required):	ASU Employee ID (10 Digit):			
	Relationship (check one): ☐ Spouse ☐ Child		Select Plan(s): ☐ Medical ☐ Dental ☐ Vision		

Section C: Enrollment Request – Check one box in 1 or 2

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☐ **New Hire**	☐ **Rehire**	☐ **Newly Eligible**	☐ **Transfer/Re-employed from another Arizona university or state agency**
I have not previously worked for ASU	I previously worked for ASU in a **benefits-eligible position** and had a break in service of: ☐ 30 days or less ☐ More than 30 days but less than12 months ☐ 12 or more months	I have been working for ASU and recently became eligible to elect benefits	Check One: ☐ NAU ☐ UA ☐ Arizona state agency: Last Day of Employment: Arizona university or state agency contact name: Phone: Email:

2 ☐ Qualified Life Event (QLE) Date Event: **Supporting documentation required**

Enroll/Add	Remove	Miscellaneous
Employee: ☐ Change in legal marital status ☐ Loss of eligibility or other coverage ☐ Returns from unpaid leave (only if benefits were voluntarily cancelled at start of leave) ☐ Moves into USA	Employee: ☐ Change in legal marital status ☐ Gains other coverage ☐ Begins unpaid leave ☐ Moves from USA ☐ Death	☐ Cancel Dependent Life ☐ Cancel Short-term Disability ☐ Significant change in day care expense or provider ☐ Non-payment of premiums during leave ☐ Eligible for LTD benefits ☐ Open Enrollment ☐ Other/please explain:
Spouse: ☐ Change in legal marital status ☐ Loss of eligibility or other coverage ☐ Moves into USA	Spouse: ☐ Change in legal marital status ☐ Gains other coverage ☐ Moves from USA ☐ Death	
Child(ren): ☐ Birth or Adoption ☐ Placement for adoption or Foster care ☐ Legal guardianship ☐ Loss of eligibility or other coverage ☐ Moves into USA ☐ Qualified Medical Child Support Order	Child(ren): ☐ Reaches maximum age ☐ Gains other coverage ☐ Moves from USA ☐ Death	

For HR Use Only	Date Received	Effective Date	Reviewed By	Cobra QLE? ☐ Yes ☐ No	PS Entered Date	PS Entered By	ADOA Entered Date	ADOA Entered By

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Section D: Health Plans

	Medical Plans (Check one)	Coverage Level (Check one)	Provider (Check one) — Triple Choice Plan - TCP	Provider (Check one) — High Deductible Health Plan w/HSA
1	☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ Employee ☐ Employee + Adult ☐ Employee + Child ☐ Employee + Family	☐ BCBS ☐ UnitedHealthcare	☐ BCBS ☐ UnitedHealthcare To enroll in the Health Savings Account, go to Section F.

	Dental Plans (Check one)	Coverage Level (Check one)	Provider (Check one) — PPO	Provider (Check one) — DHMO
2	☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ Employee ☐ Employee + Adult ☐ Employee + Child ☐ Employee + Family	☐ Delta Dental Available nationwide	☐ Cigna Dental Not available in: AK, HI, ME, MT, NH, ND, RI, SD, VT, WV, WY, Puerto Rico, US Virgin Islands.

	Vision Plans (Check one)	Coverage Level (Check one)	Provider
3	☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ Employee ☐ Employee + Adult ☐ Employee + Child ☐ Employee + Family	Avesis

Section E: Flexible Spending Accounts (FSA)

Elect **calendar-year** annual amounts, not per-pay-period amounts

1	**Health Care FSA**		
	☐ Enroll - Annual election: $ Minimum $52	☐ Change annual election, From: $ To: $	☐ Decline ☐ No Change
2	**Child/Adult Day Care FSA**		
	☐ Enroll - Annual election: $ Minimum $52	☐ Change annual election, From: $ To: $	☐ Decline ☐ No Change
3	**Limited Health Care FSA** (Available only to HDHP medical plan participants)		
	☐ Enroll - Annual election: $ Minimum $52	☐ Change annual election, From: $ To: $	☐ Decline ☐ No Change

Section F: Health Savings Account (HSA)

(Available only to HDHP medical plan participants) Elect a **calendar-year** annual amount, not a per-pay-period amount

☐ Enroll - Annual election: $	☐ Change annual election, From: $ To: $	☐ Decline ☐ No Change

Section G: Short-term Disability Insurance (STD)

Select only one STD provider (Unum or MetLife)

STD Plan (Check one)	Provider (Check **one provider only**) — Unum	Provider (Check **one provider only**) — MetLife
☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ Option A (Maximum Weekly Benefit: $750) ☐ Option B (Maximum Weekly Benefit: $1,500) ☐ Option C (Maximum Weekly Benefit: $2,000) *Weekly Benefit: 70% of covered salary subject to maximums* **Note:** Unum enrollment includes a $5,000 group life and AD&D policy. To designate beneficiaries, complete a Unum Beneficiary Designation form and fax it to 480-993-0007.	☐ MetLife (Maximum Weekly Benefit: $897.43) *Weekly Benefit: 66 2/3% of covered salary subject to maximum weekly benefit*

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Section H: Life Insurance

ASU Life

Emp Supplemental	Coverage Level	Information
☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ 1x Annual Base Salary ☐ 2x Annual Base Salary ☐ 3x Annual Base Salary ☐ *4x Annual Base Salary ☐ *5x Annual Base Salary	• Maximum without evidence of good health (EOI): Lesser of 3x or $500,000. • Maximum with evidence of good health (EOI): $1,250,000. • Coverage amount is rounded up to the nearest $1,000 increment. • At age 70, coverage is reduced by 60%. • At age 75, coverage is reduced by 75%. *Requires evidence of good health (EOI) and underwriting approval. Learn more about Securian EOI rules: cfo.asu.edu/evidence-insurability
Child(ren)	**Coverage Level**	**Information**
☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ Child(ren) $2,500 ☐ Child(ren) $7,500 ☐ Child(ren) $12,500 ☐ Child(ren) $25,000	• ASU Life child insurance cannot exceed 100% of your combined ASU Basic Life and ASU Employee Supplemental Life Insurance coverage.
Spouse	**Coverage Level**	**Information**
☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ Spouse $5,000 ☐ Spouse $15,000 ☐ Spouse $25,000 ☐ *Spouse $50,000	• ASU Life Spouse Insurance (spouse coverage amount) cannot exceed 100% of your combined ASU Basic Life and ASU Employee Supplemental Life Insurance coverage. *Requires evidence of good health (EOI) and underwriting approval. Learn more about Securian EOI rules: cfo.asu.edu/evidence-insurability.

ADOA Life

Emp Supplemental	Coverage Level	Information
☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	Indicate your coverage amount $ 0	• Available in $5,000 increments. • Maximum: $500,000 or 3x annual base salary, whichever is less. • Coverage is rounded down to the nearest $5,000 increment.
Spouse/Child(ren)	**Coverage Level**	**Information**
☐ Enroll ☐ Decline/Cancel ☐ Change ☐ No Change	☐ $ 2,000 ☐ $12,000 ☐ $ 4,000 ☐ $15,000 ☐ $ 6,000 ☐ $50,000 ☐ $10,000	• ADOA Dependent Life Insurance cannot exceed 100% of your combined ADOA Basic Life and Supplemental Life Insurance coverage. • Married faculty and staff members cannot both elect ADOA Dependent Life. This restriction does not apply to ASU Life child/ASU Life spouse.

HR Use Only			
	ASU Life-emp supp	$ 0.00 Annual Salary x 0 Coverage Level = $ 0.00 Subtotal Subtotal Rounded up to nearest $1,000 = ___________ Coverage	EOI Required? ☐ Yes - Added to SS on: ___________ ☐ No
	ASU Life child	___________ Basic + ___________ Supp = 0 (Total Employee Coverage)	Is employee coverage greater than dependent? ☐ Yes ☐ No
	ASU Life spouse	___________ Basic + ___________ Supp = 0 (Total Employee Coverage)	EOI Required? ☐ Yes - Added to SS on: ___________ ☐ No Is employee coverage greater than dependent? ☐ Yes ☐ No
	ADOA Sp/Ch	___________ Basic + ___________ Supp = 0 (Total Employee Coverage)	Is employee coverage greater than dependent? ☐ Yes ☐ No

Section J: Acknowledgement and Authorization

I certify under penalty of perjury that the information provided in this application for employee benefits, including social security numbers, addresses, spouse and/or dependent child(ren) information, is true and accurate. I further understand that providing false information may subject me to a denial of employee benefits, disciplinary action and prosecution pursuant to A.R.S. §13-2310, 13-2311, 13-2407, 13-2702 and other applicable provisions of the law. I authorize the release of this information to my employer, the Arizona Department of Administration, and insurance carriers. Further:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions (in accordance with IRC Section 125), either prospectively or retroactively, for my elected benefits. Any pre-tax contributions are ineligible as itemized deductions for income tax purposes.
- I understand that I can only change my benefits during open enrollment or by written notification to HR Benefits within 30 calendar days of a qualified life event.
- I understand that while on any unpaid status, I am responsible for paying my benefits premiums. Upon return to paid status, I may have pre-tax or after-tax payroll deductions. If I fail to pay premiums as required, my benefits may be cancelled and I will be responsible for any paid claims.

Print Name:	Signature:	Date:
Employee ID (10 digit):	Email Address:	