BCBS

EMPLOYEE APPLICATION

EFFECTIVE DATE OF COVERAGE

BCBSAZ ID NUMBER (existing member)

EMPLOYEE NUMBER (employer use only)

MEDICAL PLAN TYPE
- ○ PPO Base
- ○ PPO Buy Up
- ○ Saver HDHP
- ○ Other

} _____ OPTION

MEDICAL COVERAGE
- ○ EMPLOYEE ONLY
- ○ EMPLOYEE & SPOUSE
- ○ EMPLOYEE & CHILDREN
- ○ FAMILY

ARE YOU DECLINING COVERAGE FOR:

	MEDICAL _____
SELF?	○ Y ○ N
SPOUSE?	○ Y ○ N
DEPENDENT(S)?	○ Y ○ N

If yes, include the appropriate reason code(s) in Section II below. (A list of reason codes is found near the bottom of page 2.)

- ○ NEW GROUP OPEN ENROLLMENT

SECTION I – INFORMATION REGARDING YOUR EMPLOYER

EMPLOYER NAME | LOCATION | GROUP NUMBER | JOB CLASSIFICATION ○ I ○ II ○ OTHER (SEE EMPLOYER)

SECTION II – INFORMATION REGARDING THE EMPLOYEE

MARK ONE: ○ ADD ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

SOCIAL SECURITY NUMBER Required. See (O) on page 2. | LAST NAME | FIRST NAME | M.I.

PHYSICAL ADDRESS (NUMBER, STREET & APARTMENT NO.) | CITY | STATE | ZIP + FOUR

MAILING ADDRESS | CITY | STATE | ZIP + FOUR

DATE OF BIRTH (MM/DD/YYYY) | MALE ○ | FEMALE ○ | MARRIED ○ | SINGLE ○ | DATE OF MARRIAGE (MM/DD/YYYY) | WORK TELEPHONE (AREA CODE AND NO.) | HOME TELEPHONE (AREA CODE AND NO.)

EMAIL ADDRESS | See page 2 (N) regarding e-mail authorization

OTHER COVERAGE INFORMATION: Will you or your dependents be covered by other health insurance in addition to BCBSAZ? YES ○ NO ○
If yes, please complete the other coverage information below.

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | ID/SOCIAL SECURITY NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

Complete the following for all dependents. If you have more than 3 dependents, complete a separate form.
New employees: Complete the following information for each eligible dependent including those declining or waiving coverage.
Enrolled employees: to add or remove dependent(s) or change coverage options, only include the persons affected by the change.

1 MARK ONE: ○ ADD ○ DELETE ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

LAST NAME | FIRST NAME | M.I.

SOCIAL SECURITY NUMBER Required. See (O) on page 2 | DATE OF BIRTH (MM/DD/YYYY) | MALE ○ FEMALE ○ | RELATIONSHIP

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | IDENTIFICATION NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

2 MARK ONE: ○ ADD ○ DELETE ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

LAST NAME | FIRST NAME | M.I.

SOCIAL SECURITY NUMBER Required. See (O) on page 2 | DATE OF BIRTH (MM/DD/YYYY) | MALE ○ FEMALE ○ | RELATIONSHIP

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | IDENTIFICATION NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

3 MARK ONE: ○ ADD ○ DELETE ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

LAST NAME | FIRST NAME | M.I.

SOCIAL SECURITY NUMBER Required. See (O) on page 2 | DATE OF BIRTH (MM/DD/YYYY) | MALE ○ FEMALE ○ | RELATIONSHIP

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | IDENTIFICATION NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

I certify to all of the following on behalf of myself and the persons listed on this application as eligible dependents: (1) I have read this entire form, (2) I understand and agree to its terms; (3) I apply for enrollment and/or waive group benefits as indicated on this form, subject to all terms and conditions of the coverage, as offered by my employer; (4) the information I have provided is accurate and complete, and I understand that provision of false information may result in fines and criminal penalties; and (5) if any part of any premium for coverage or other financial services will be paid through payroll deduction, I authorize my employer to periodically deduct from my wages, and remit amounts necessary to continue the coverage and any services.

X _____
EMPLOYEE'S SIGNATURE

_____
DATE

PAGE 1 OF _____ PAGE 2 OF _____ PAGE 3 OF _____

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

HealthEquity

Health Savings Account
Employee Enrollment Form

Employer _____

Qualified for a Health Savings Account

This enrollment form is to open a Health Savings Account that is used to accumulate assets for the payment of qualified healthcare expenses. Your Health Savings Account is your financial asset even if you change employers or health plans. To open a Health Savings Account you must meet three criteria:

1) You must be covered by a qualified high deductible health plan,
2) You cannot be covered by another health plan, including Medicare
3) You cannot be claimed as a dependent on another individual's tax return.

Personal Information

Name: First: _____ Last: _____ Middle Initial: _____

Street Address: Street: _____

City: _____ State: _____ Zip: _____

Mailing Address Street: _____

(if different) City: _____ State: _____ Zip: _____

Date of Birth: _____ Email: _____ (for statements and notices)

Contact Phone: (_____)_____ Social Security Number: _____ Gender: ☐ M ☐ F

Insurance Coverage: Coverage Effective Date _____ Coverage Type: ☐ Single ☐ Family

Authorization and Certification

- I accept the terms of the HealthEquity HSA enrollment form and the HSA Custodial Agreement.

Signature

_____ _____ _____

Print Name Signature Date

The balance in your Health Savings Account is insured up to $100,000 by the Federal Deposit Insurance Corporation (FDIC).

***Please mail this completed from to your Human Resources representative.**

NAPEBT Supplemental Election Form
for High Deductible Health Plan Participants

Direction of the Employer Premium Savings Contributions 7/1/11-6/30/2012
AND for additional employee Health Savings Account contribution 7/1/11 through 12/31/2011

This election form should be filled out by all High Deductible Health Plan participants.
Nothing on this form is to be considered tax advice.
You must consult with your personal tax advisor on any personal income tax issues.

1. Employee Information

Name: _____ Employee I.D.#: _____

High Deductible Health Plan Coverage Type: Employee Only ☐ Family ☐

2. Employer Premium Savings Contribution

Please check one of the following:

☐ **I am eligible for a Health Savings Account. Please deposit my employer premium savings contribution in a Health Savings Account.** *Be sure to also complete the Health Equity enrollment Form if you have not enrolled with them previously.*

☐ **I am ineligible for a Health Savings Account. Please deposit my employer premium savings contribution into a General Purpose Health Care Flexible Spending Account (FSA).** *Be sure to also complete the ASIFlex FSA enrollment form. Skip sections 3 and 4 of this form.*

3. Employee HSA Contribution Worksheet

1. 2011 IRS Calendar Year Limit For HSA Contributions (Enter $3050 if you elected employee only HDHP coverage or $6150 if you elected Family HDHP coverage)	1. $_____
2. 2011 Catch-up Contribution (Enter $1000 if you are over 55 years old)	2. $_____
3. 2011 Total allowable contribution (add items 1 and 2)	3. $_____
4. Contribution made by Employee between 1/1/2011 and 6/30/2011 (If you are unsure of what you elected last plan year, contact Human Resources)	4. $_____
5. Contributions made by Employer between 1/1/2011 and 6/30/2011 (If you participated in the HSA through NAPEBT for the entire period, enter $264.72)	5. $_____
6. Employer Contribution for remainder of calendar year. (1/2 of $332.16=$166.08)	6. $
7. Total allowable employee contribution for 7/1/11-12/31/2011 (subtract items 4,5 & 6 from item 3)	7. $_____
8. Total desired employee contribution for 7/1/11-12/31/11 (must be equal to or less than item 7)	8. $_____

Note: The calculations in this worksheet will not be applicable if your spouse also has a health savings account.

4. Employee Acknowledgement/HSA Contribution Election

Reminder: To contribute to a Health Savings Account you must meet three criteria:

1) You must be covered by a HSA-qualified high deductible health plan (HDHP), and
2) You cannot be covered by another health plan, including Medicare, and
3) You cannot be claimed as a dependent on another individual's tax return.

The maximum employee contribution amount, combined with your NAPEBT employer contribution, cannot exceed the IRS stated maximums for the calendar year. Individuals age 55 and older can make additional catch-up contributions. Check the IRS guidelines for maximum contributions at www.treas.gov and click on Health Savings Accounts.

NAPEBT employers contribute a prorated amount each month ($27.68) for each month you maintain HDHP coverage.

Your HSA contribution election will be deducted from your paycheck in equal amounts for the period of your election.

I would like to contribute the following amount to my Health Savings Account, through pre-tax payroll deductions:

$ _____ for the remainder of calendar year 2011 ($_____ per pay period)

- I authorize my employer to reduce my pay before taxes on a "per pay period" basis as indicated above.
- I understand my contribution election (if any) is for calendar year 2011 and that I can add, change or revoke my HSA contribution once annually and when given permission by the Human Resources Director in accordance with the Plan's HSA rules.
- I understand that my changes must be prospective in accordance with Internal Revenue Code (IRC) rules.
- I understand that my election contributions must comply with federal regulations and NAPEBT's internal plan guidelines.
- I understand that to avoid taxes, the reimbursement requests I will be submitting to my HSA account must be IRC eligible medical expenses and that I must not have been previously reimbursed for these expenses from insurance or any other source.
- I understand that I will need to make new elections for calendar year 2011.

5. Signature

Print Name _____

Signature _____ Date _____, 20____

Return this completed Employee Contribution Election form to your Human Resources Department before the enrollment deadline.

For internal employer use only

Contributions reviewed and entered by _____. Date: ___/___/___

VSP

Vision Plan
ENROLLMENT/CHANGE FORM
NAPEBT – 12239817

☐ Add
☐ Change
☐ Cancel

EFFECTIVE DATE: _____ **EMPLOYEE'S SSN:** _____

EMPLOYEE'S NAME: _____

EMPLOYEE'S DATE OF BIRTH: _____

☐ I WOULD LIKE TO ENROLL IN THE VSP EXAM PLUS PROGRAM.

☐ I WOULD LIKE TO ENROLL IN THE BUY UP PROGRAM AND THE TYPE OF COVERAGE REQUESTED IS:

C ☐ EE Only
A ☐ EE+Family

PLEASE LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER:

SPOUSE: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____
CHILD: _____ ☐Male ☐Female DOB _____

_____ _____
Signature Date

Please return to your Benefits Department
<u>Do Not Return</u> to Vision Service Plan

DELTA DENTAL

SECTION F: Employer Use Only

Employer Name: _____	Group Number: _____
Effective 1st Day Of: ____/____ (MM/YYYY)	Sub-location: _____

Enrollment Application/Change of Status Form

Instructions on reverse side.

SECTION A: Qualifying Event

☐ **NEW HIRE** (Complete sections B, C, D, E)
☐ **OPEN ENROLLMENT** (Complete sections B, C, D, E)
☐ Dental
Plan:
☐ Premier
☐ PPO plus Premier
☐ PPO
☐ enhanced Premier
Option:
☐ High/Buy-up
☐ Low/Base
☐ Vision

☐ **DECLINE COVERAGE** (Complete sections B, D, E)
☐ Dental ☐ Vision

☐ **CHANGE OF STATUS** (Complete sections B, C, D, E)
☐ Dental ☐ Vision

☐ Cancel Coverage (Complete section B, E) ☐ COBRA (Complete sections B, C, D, E)

☐ Address Change (Complete section B, E)

☐ Name Change To: _____ From: _____

☐ Add/Delete Dependent(s) (Complete sections B, C, E)
☐ Marriage ☐ Birth ☐ Retire
☐ Divorce ☐ Adoption ☐ Loss of Coverage ☐ Other - Reason: _____

SECTION B: Employee Information

Social Security Number/EIN	Employer Name	Marital Status ☐ Single ☐ Married
Employee's Last Name	First / MI	Gender ☐ M ☐ F
Home Address (Mailing)		Date of Birth____/____/_____ (MM/DD/YYYY)
City / State / Zip	Email	

SECTION C: Dependent Information

Add	Change	Delete	Last Name (If different), First, MI	Dental	Vision	Relationship to Employee	Gender M / F	Date of Birth	Full-Time Student Y / N
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	

SECTION D: Other Coverage Information

Do you or any member of your family have coverage under another group dental insurance plan?
☐ YES – Please check the appropriate box(es) and complete Section D ☐ NO – Please skip to Section E
☐ Medical ☐ Dental ☐ COBRA ☐ Retiree ☐ Vision

Insurance Company Name	Effective Date of Coverage ____/____/____ (MM/DD/YYYY)
Name of Policyholder	Policyholder's Date of Birth ____/____/____ (MM/DD/YYYY)

Please indicate to whom this coverage applies (Check all that apply). ☐ Self ☐ Spouse ☐ All Children ☐ Child(ren) _____ Name(s)

Name of Dependent	Relationship to Policyholder

SECTION E: Authorization

I hereby apply for coverage with Delta Dental of Arizona pursuant to the terms specified on the reverse side of this form, which are hereby incorporated by reference.

Employee's Signature/Authorization _____ Date Signed (MM/DD/YYYY) _____ Employer's Signature/Authorization _____ Date Signed (MM/DD/YYYY) _____

DD4E2-5002-rev0316

I apply for benefits with Delta Dental of Arizona (Delta Dental), and on behalf of any dependents and myself, I agree to be bound by the provisions of my dental or vision plan (the Plan). If accepted, this application, the identification card and the group contract will constitute the Plan.

I understand and agree that my coverage and that of any dependents will become effective on the date established by my employer in Section F. Any dependents that are added to my Plan later will have different effective dates.

My employer or group administrator is authorized to deduct my share of dental premiums, if any, from my wages for 12 months and during any renewal periods. My employer or group administrator is authorized to remit a premium to Delta Dental and to receive all notices from Delta Dental relating to my coverage. I understand that enrollment is for consecutive 12-month period, and my contribution is subject to change on renewal. Further, I understand that non-compliance with these terms voids any benefits during an enrollment period.

I will notify Delta Dental upon any change that would make me or any dependent ineligible for coverage.

I will cooperate with Delta Dental and furnish all information requested to enforce Delta Dental's right to coordinate benefits.

I understand that Delta Dental may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. If false or misleading information is discovered, Delta Dental may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application. Any claims paid during the periods when the coverage was not in force will be deducted from the premium refund. If the benefits paid by Delta Dental exceeds the premium paid, I agree to refund any excess amount to Delta Dental.

Uses and Disclosures of Health Information: At Delta Dental, we use health information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. For more information about our privacy practices, please visit www.deltadentalaz.com under privacy policy or contact Customer Service, Phone: 602.938.3131 or 800.352.6132, Email: customerservice@deltadentalaz.com.

Instructions

SECTION A - Determine the Qualifying Event

Please check or complete all boxes that indicate whether you are a new enrollee or you are requesting an update to your current coverage. If you are requesting a coverage update, select the appropriate qualifying event and indicate the date of the event.

New Hire/Open Enrollment: Select the dental plan offered by your employer. If vision is being offered and you would like to apply for coverage, please check the vision box. Please complete Sections B, C, D, and E.

Decline Coverage: If you would like to decline dental or vision coverage, please check the dental and/or vision option. Please complete sections B, D, and E.

Change of Status:

- **Cancel Coverage** - Check the Cancel Coverage box and complete sections B and E.
- **COBRA** - Check the COBRA box and complete sections B, C, D, and E.
- **Address Change** - Check the address change box and complete section B and E.
- **Add/Delete Dependent(s)** - Please indicate the qualifying event add the date of the event. Please complete sections B, C, and E.

SECTION B - Employee Information

Please complete this section in its entirety for all circumstances.

SECTION C - Dependent Information

Check either add, change or delete to select the appropriate dependent action. Complete dependent information and select the dental or vision option to apply for coverage or to make the selected updates.

SECTION D - Other Coverage Information

Complete this section if you or any of your dependents have additional dental coverage that will not be cancelled when this plan becomes effective.

SECTION E - Authorization

Once you have completed the appropriate sections and reviewed the terms above, please sign and date this form.
Employer: Sign and date this form before submitting to Delta Dental of Arizona.

SECTION F - Employer Use Only

Submit the signed form to your employer, who will complete section F.
Employer: Complete section F before submitting to Delta Dental of Arizona.

Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • B1-3102 • St. Paul, Minnesota 55101-2098 • Fax 651-665-7092

MINNESOTA LIFE

GROUP NAME: NAPEBT **POLICY NUMBER: 33585**

Employer Name: ☐ **Coconino County** ☐ **CCRASD** ☐ **NAIPTA**

1. Complete sections A, B, and E.
2. If you are electing coverage on your dependents, complete sections C and/or D.
3. Please send completed form to your local Human Resources office.

A. EMPLOYEE INFORMATION

First name | Middle initial | Last name

Email address

Street address | City | State | Zip code

Date of birth | Social Security number | Date of employment | Gender ☐ Male ☐ Female

Annual salary
$

B. VOLUNTARY COVERAGE OPTIONS (select the coverage types and amounts below)

Voluntary term life (increments of $10,000 to a maximum of $500,000, not to exceed 5x salary)
☐ $ ☐ Waive

Dependent term life
Spouse coverage ($5,000 increments to a maximum of $100,000, or 100% of employee's combined basic and voluntary amount, whichever is less) ☐ $ ☐ Waive

Child coverage
☐ $10,000 ☐ Waive

C. SPOUSE INFORMATION

First name | Middle initial | Last name

Email address

Date of birth | Social Security number | Gender ☐ Male ☐ Female

D. CHILDREN INFORMATION - List of names and dates of birth for your eligible children

Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth

E. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for voluntary insurance coverage.

Employee signature | Daytime phone number | Evening phone number | Date signed

X

FOR OFFICE USE ONLY (complete if Evidence of Insurability is required)

ER code: 1 = Coconino County 2 = CCRASD 3 = NAIPTA

Voluntary Life	Spouse Life	Child Life
Current coverage $	Current coverage $	Current coverage $
Guaranteed issue $	Guaranteed issue $	Guaranteed issue $
Total elected $	Total elected $	Total elected $
Underwritten amt $	Underwritten amt $	Underwritten amt $

Basic Life and AD&D Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • B1-3102 • St. Paul, Minnesota 55101-2098 • 651-665-7092

MINNESOTA LIFE

GROUP NAME: NAPEBT **POLICY NUMBER: 33585**

Employer Name: _____

EMPLOYEE INFORMATION

First name	Middle initial	Last name

Email address

Street address	City	State	Zip code

Date of birth	Social Security number	Date of employment	Gender ☐ Male ☐ Female

Annual salary	Occupation
$	

AUTHORIZATION

Employee signature	Daytime telephone number	Evening telephone number	Date signed
X			

EXAMPLES OF BENEFICIARY DESIGNATIONS

- If there is only one person designated, you need not designate a contingent. For example: Jane Doe, wife.
- If naming a Formal Trust, the following information is needed:

Full Name of Trustee	Address (if Institution)
Name of Trust	Date of Trust

Example 1: If only one person is to receive the proceeds

	BENEFICIARY NAME & ADDRESS	RELATIONSHIP TO INSURED	SHARE %
Primary	Mary Doe 123 4th Street Somewhere US 98765	Daughter	100%

Example 2: If a primary beneficiary is to receive the proceeds first, followed by a contingent beneficiary, if the primary beneficiary is deceased.

	BENEFICIARY NAME & ADDRESS	RELATIONSHIP TO INSURED	SHARE %
Primary	Jane Doe 123 4th Street Somewhere US 98765	Wife	100%
Contingent	The then living child or children born of the Insured's marriage with the said Jane Doe.		

Example 3: If a primary beneficiary is to receive the proceeds first, followed by contingent beneficiaries who will share funds equally, if the primary beneficiary is deceased.

	BENEFICIARY NAME & ADDRESS	RELATIONSHIP TO INSURED	SHARE %
Primary	Jane Doe 123 4th Street Somewhere US 98765	Wife	100%
Contingent	Nancy Doe 123 4th Street Somewhere US 98765	Sister	50%
Contingent	Jim Doe 123 4th Street Somewhere US 98765	Father	50%

Example 4: The primary beneficiaries receive the proceeds first, followed by the contingent beneficiary, if all primary beneficiaries are deceased.

	BENEFICIARY NAME & ADDRESS	RELATIONSHIP TO INSURED	SHARE %
Primary	Mary Doe 123 4th Street Somewhere US 98765	Friend	75%
Primary	Beth Doe 123 4th Street Somewhere US 98765	Daughter	25%
Contingent	Jack Doe 123 4th Street Somewhere US 98765	Son	100%

Example 5: If beneficiary is a formal trust.

	BENEFICIARY NAME & ADDRESS	RELATIONSHIP TO INSURED	SHARE %
Primary	John Doe-Trustee, his successors or successor in trust under the **John Doe Revocable Trust Agreement.** Executed by the insured on June 1, 1991.		

DO NOT SEND COPY OF TRUST UNTIL PRESENTING A CLAIM.