


**ARIZONA METROPOLITAN TRUST (AzMT)
BUCKEYE VALLEY FIRE DISTRICT**

BENEFIT ENROLLMENT/CHANGE FORM

| | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------|------------------------|--------------------------------------------------|
|  | EMPLOYMENT STATUS | | EFFECTIVE DATE OF COVERAGE/CHANGE | | | |
| | <input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA | | | | | |
| SOC. SEC. # | EMPLOYEE'S LAST NAME | | FIRST NAME | | MIDDLE INITIAL | |
| MAILING ADDRESS | | CITY | STATE | ZIP CODE | HOME PHONE NUMBER | EMAIL ADDRESS |
| MARITAL STATUS | | GENDER | | DATE OF BIRTH | DATE OF FULL TIME HIRE | HOURS WORKED PER WEEK (ACTIVE EMPLOYEES ONLY) |
| <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DOMESTIC PARTNER | | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | MONTH DAY YEAR | MONTH DAY YEAR | |
| COVERAGE OPTIONS | | | | | | |
| MEDICAL - EPO <i>(Dependent children are eligible up to age 26*)</i> | | <input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage** | | | | |
| MEDICAL - PPO <i>(Dependent children are eligible up to age 26*)</i> | | <input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage** | | | | |
| MEDICAL - PPO BUY-UP <i>(Dependent children are eligible up to age 26*)</i> | | <input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage** | | | | |
| MEDICAL - HDHP <i>(Dependent children are eligible up to age 26*)</i> | | <input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage** | | | | |
| ENROLL IN HSA? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete separate forms available from Administration) <i>(Only available for those enrolling in the HDHP)</i> | | | | | | |
| DENTAL <i>(Dependent children are eligible up to age 19 only)</i> | | <input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage** | | | | |
| VISION <i>(Dependent children are eligible up to age 19 only)</i> | | <input type="checkbox"/> Employee <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Child(ren) <input type="checkbox"/> Emp + Family <input type="checkbox"/> Waive Coverage** | | | | |
| *NOTE: Eligible children include natural, step, adopted, or children for which you have legal guardianship. Please refer to your current Summary Plan Document for full eligibility requirements. | | | | | | |
| **Employees waiving coverage must complete the Waiver of Coverage located on Page 2 of this Benefit Enrollment/Change Form | | | | | | |

IMPORTANT: YOU MUST FULLY COMPLETE THE FOLLOWING IF SPOUSE/DOMESTIC PARTNER AND/OR DEPENDENT COVERAGE IS BEING REQUESTED

| ADD | DEL | NAME | DATE OF BIRTH | SOCIAL SECURITY # (REQUIRED) | RELATION | PLAN |
|-----|-----|------|---------------|---------------------------------|----------|----------------------------------------------------------------------------------------------|
| | | | | | | <input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
| | | | | | | <input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
| | | | | | | <input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
| | | | | | | <input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision |

| OTHER INSURANCE INFORMATION | |
|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| Do you or your dependents currently have other: Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, give name of policyholder, policy #, name of insured, insurance company and, if applicable, termination date. |
| If anyone is currently on Medicare please provide the following: | ID Number _____ Part A Effective Date ____/____/____ Part B Effective Date ____/____/____ Part D Effective Date ____/____/____ |

| AUTHORIZATION AND SIGNATURE |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. I hereby apply for benefits to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the policyholder. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this benefit.</p> <p>The information provided above is correct to the best of my knowledge. I certify under penalty of perjury that the dependents listed on this form fully meet the listed definition of eligibility. I will provide, if requested, documentation regarding my relationship (birth certificate, adoption certificate, etc.) to any dependent and his/her age. I will notify my employer within 31 days of a change in my listed dependents eligibility for employer-provided health benefits. I understand that if I do not enroll myself or my dependents, I must read and sign the waiver portion of this form.</p> |
| <p>_____ Signature of Employee</p> <p style="text-align: right;">_____ Date</p> |

| WAIVER OF COVERAGE (COMPLETE AND SIGN THIS SECTION IF YOU ARE WAIVING COVERAGE) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><input type="checkbox"/> Medical/Rx benefits are being waived for (Name) _____ for the following reason(s): _____</p> <ul style="list-style-type: none"> • Group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. • I waive coverage for myself and/or my dependents and elect not to participate. • I understand that I am waiving this coverage even though my employer may be providing the coverage at little or no cost to me. • I understand that by waiving enrollment because of other health insurance coverage, I may in the future be able to enroll in this plan, provided that I request enrollment within 31 days after other coverage ends. In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself or my dependents provided that I request enrollment within 31 days of the status change. • I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. |
| <p>_____ Signature of Employee</p> <p style="text-align: right;">_____ Date</p> |

| TO BE COMPLETED BY ADMINISTRATION ONLY | | |
|---------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> New Employee/Rehire | Hire/Rehire Date ____/____/____ | Effective Date ____/____/____ |
| <input type="checkbox"/> Add/Delete Dependents | Effective Date of Change ____/____/____ | Qualifying Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Termination of Employment |
| <input type="checkbox"/> Termination of Insurance | Termination Date ____/____/____ | <input type="checkbox"/> Loss of Dependent Status <input type="checkbox"/> Death of Employee <input type="checkbox"/> Other |
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Name/Address Change | Date of Qualifying Event ____/____/____ Name _____ |
| | | HR Dept. Initials _____ Date ____/____/____ |