ARIZONA METROPOLITAN TRUST (AzMT)
PARADISE VALLEY

BENEFIT ENROLLMENT/CHANGE FORM

EMPLOYMENT STATUS	EFFECTIVE DATE OF COVERAGE/CHANGE
☐ Active Employee ☐ COBRA	

SOC. SEC. #	EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL

MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER

MARITAL STATUS	GENDER	DATE OF BIRTH	DATE OF FULL TIME HIRE	HOURS WORKED PER WEEK (ACTIVE EMPLOYEES ONLY)
☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER	☐ MALE ☐ FEMALE	MONTH DAY YEAR		

MEDICAL COVERAGE OPTIONS

Select one health plan and one coverage level to enroll:

☐ **EPO** ☐ **PPO** ☐ **PPO BUY-UP** ☐ **HDHP** ☐ **Waive Coverage***

ENROLL IN HSA? ☐ **Yes**** ☐ **No**

☐ **Employee** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Employee + Family**

*Employees waiving coverage must complete the Waiver of Coverage located on Page 2 of this Benefit Enrollment/Change Form

**You can only enroll in the HSA if the HDHP is selected. If enrolling in the HSA separate forms are required to be filled out.

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.

DENTAL COVERAGE OPTIONS

Select one dental plan and one coverage level to enroll:

☐ **Basic Dental ($2,000 Annual Benefit)*** ☐ **Buy-Up Dental ($4,000 Annual Benefit)****

☐ **Employee** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Employee + Family**

**Basic Dental Plan – Dependent children are eligible up to age 19 only.*
***Buy-Up Dental Plan – Dependent children are eligible up to age 26.*

VISION COVERAGE OPTIONS

Select one vision plan and one coverage level to enroll:

☐ **Basic Vision*** ☐ **Buy-Up Vision****

☐ **Employee** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Employee + Family**

**Basic Vision Plan – Dependent children are eligible up to age 19 only.*
***Buy-Up Vision Plan – Dependent children are eligible up to age 26.*

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
						☐ Med ☐ Dental ☐ Vision
						☐ Med ☐ Dental ☐ Vision
						☐ Med ☐ Dental ☐ Vision
						☐ Med ☐ Dental ☐ Vision
						☐ Med ☐Dental ☐ Vision

OTHER INSURANCE INFORMATION

Do you or your dependents currently have other: Medical Insurance? ☐ Yes ☐ No	If Yes, give name of policyholder and insurance company.
If anyone you are requesting coverage for 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

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.

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 (marriage or birth certificate, adoption certificate, divorce decree, 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.

_____ _____

Signature of Employee **Date**

WAIVER OF COVERAGE (COMPLETE AND SIGN THIS SECTION IF YOU ARE WAIVING COVERAGE)

☐ Medical/Rx benefits are being waived for (Name) _____ for the following reason(s): _____

_____

- 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.

_____ _____

Signature of Employee **Date**

TO BE COMPLETED BY HUMAN RESOURCES ONLY

☐ New Employee/Rehire	Hire/Rehire Date _____/_____/_____	Effective Date _____/_____/_____
☐ Add/Delete Dependents	Effective Date of Change _____/_____/_____	Qualifying Event: ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption ☐ Termination of Employment ☐ Loss of Dependent Status ☐ Death ☐ Other
☐Termination of Insurance	Termination Date _____/_____/_____	Date of Qualifying Event _____/_____/_____ Name _____
☐ Open Enrollment	☐ Name/Address Change	HR Dept. Initials _____ Date _____/_____/_____ Data Input:_____ (HR Initials)