

Health Insurance Authorization/Change Form

1	PSPRS	EORP	CORP
2	SUBSIDY ONLY DIRECTBILL	Is this retiree also retired from ASRS Yes No	PENSION DEDUCTION
3	New Retiree/Survivor	Change Coverage	Term Coverage
	Medical Change only	Medical and Dental Change	Dental Change only
MEMBER INFORMATION			
	LAST NAME	FIRST NAME	M.I.
	SOCIAL SECURITY NUMBER		
4	MAILING ADDRESS	STREET & NO.	
		DATE OF BIRTH	SEX M/F
	CITY	STATE	ZIP
		PHONE	
PLAN SELECTION			
5	MEDICAL CARRIER & PLAN		DENTAL CARRIER & PLAN
	SINGLE	FAMILY	SINGLE FAMILY
COST FOR COVERAGE			
	MEDICAL		DENTAL
6	Member Cost		Member Cost
	Dependent Cost		Dependent Cost
	Total Due		Total Due
EFFECTIVE DATE FOR COVERAGE			
7	DATE (MM/DD/YYYY), _____		
DEPENDENT INFORMATION			
	Name	M/F	D.O.B.
	SS#	Medicare #	Effective date of Medicare
8			
IF THERE ARE ADDITIONAL DEPENDENTS PLEASE LIST ON A SEPARATE PAGE			
EMPLOYER SECTION			
	Employer Rep Signature		Date
9	Employer Name:		Employer Contact Phone:
	Rep Name:		
Send this form either to our fax at 602-296-2370 or mail to 3010 E. Camelback Rd, Suite 200, Phoenix, AZ 85016 If you fax please DO NOT mail a copy as this will duplicate our work.			
PSPRS SECTION			
10	Medical Code	Dental Code	
	<input style="width: 100px; height: 20px;" type="text"/>	<input style="width: 100px; height: 20px;" type="text"/>	

REVISED 5-3-11

SECTION 1

SELECT WHICH PLAN MEMBER RETIRED FROM

SECTION 2

SELECT WHETHER THE MEMBER IS TO HAVE MONEY COME OUT OF THEIR PENSION (PENSION DEDCUTION) OR IF OUR OFFICE IS ONLY TO SEND SUBSIDY AND YOUR OFFICE WILL BILL THE MEMBER (DIRECTBILL). IF THE MEMBER IS ALSO RETIRED FROM ASRS PLEASE INDICATE BY MARKING YES IN THIS SECTION.

SECTION 3

SELECT THE REASON FOR THE CHANGE

SECTION 4

MEMBER INFORMATION

SECTION 5

ENTER IN THE INFORMATION ABOUT THE PLAN THE MEMBER IS UNDER WITH THE NAME OF THE CARRIER AND W- TYPE OF PLAN IT IS (I.E.PPO, HMO, EPO) ALSO CIRCLE WHETHER THE COVERAGE IS FOR SINGLE OR FAMILY.

SECTION 6

LIST THE COST OF THE PLAN SEPARATED OUT BY MEMBER AND DEPENDENTS AND THE TOTAL THAT THE MEMBE RESPONSIBLE FOR.

SECTION 7

EFFECTIVE DATE

SECTION 8

INFORMATION ABOUT DEPENDENTS ON THE PLAN

SECTION 9

EMPLOYER INFORMATION

SECTION 10

FOR OUR OFFICE'S USE YOU DO NOT NEED TO ENTER ANYTHING IN HERE.