PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

PO Box 17323, Phoenix, AZ 85011-0323
Phone: (602) 255-5575 Fax: (602) 296-2371

ANNUAL ENROLLMENT FORM

PRINT EMPLOYEE Full Name	SSN	Date of Birth (MM/DD/YYYY)

Address	City, State and ZIP

Home Phone	Cell Phone	Work Phone	Email Address	Have you previously been enrolled in this Plan? ❒ Yes OR ❒ No

The Cancer Insurance Program is being extended as a voluntary program pursuant to A.R.S. §§ 38-641-645 and your employer has elected to participate in this Program. Please check your election in the appropriate box below to indicate your enrollment effective date, or to decline election of the Program.

1. I understand that I am responsible for paying the full annual premium through my employer as an after-tax deduction. The current annual premium is $50.00.
2. I understand that my effective date will be July 1, _____ (enter year) if I was hired on or before this date into an eligible position.
3. I understand that I will remain enrolled in the Program as long as I am in an eligible position and I will be responsible for each additional annual premium through my employer.
4. I understand that I may be eligible to continue this Plan once I retire.
5. I understand that my enrollment will terminate effective with my date of employment termination.
6. I understand that if I transfer to another agency that is also enrolled in the Program, I will need to notify my new employer and I will need to complete a new enrollment form within 30 days of the transfer.
7. I understand that the information regarding this benefit can be located at www.psprs.com.

❒ I wish to enroll in the Cancer Insurance Program and I agree to the terms listed above.

❒ I wish to decline enrollment into the Cancer Insurance Program.

REQUIRED Employee Signature (electronic signature cannot be accepted)	Date (MM/DD/YYYY)

TO BE COMPLETED BY EMPLOYER Print EMPLOYER Name	Employee Date of Hire (MM/DD/YYYY)

Is this employee a transfer? ❒ Yes OR ❒ No	If the employee is a transfer, verify premiums were paid through the previous employer and if no premiums are due for the current fiscal year.

PRINT Name of Agency Representative	Date (MM/DD/YYYY)

REQUIRED Signature of Agency Representative (electronic signature cannot be accepted)	Date (MM/DD/YYYY)