PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

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

CORP EMPLOYER ENROLLMENT FORM

PRINT EMPLOYER Name		
Address	**City, State and ZIP**	
Contact Name	**Email Address**	**Phone**

The Cancer Insurance Program is being extended as a voluntary program to employers pursuant to A.R.S. §§ 38-641-645. This form must be received by PSPRS no later than June 15, 2019.

❒ Our agency wishes to offer the Cancer Insurance Program to our eligible employees and we agree to the Employer Terms of the Plan included below:

1. We will introduce and offer the Plan to our eligible employees.
2. We will submit Employee Enrollment Forms for participating employees to PSPRS per the Terms of the Plan.
3. We will maintain eligibility and premium payment records of the Plan for our enrolled employees.
4. We will collect the $50.00 annual premium from the enrolled member paycheck and submit those monies to PSPRS no later than August 31, 2019 for employees effective July 1, 2019.
5. We understand that the earliest effective date for employees is July 1, 2019 since our agency is opting in after the initial enrollment period.
6. We will offer this plan to our new hires throughout the year and provide an Employee Enrollment Form and premium payment to PSPRS within 45 days of hire. We understand that the full premium for that fiscal year is due regardless of the employee date of hire.
7. We understand that no refunds will be issued for employees that terminate employment.
8. We understand that each following Plan Year after our initial offering for this Plan is July 1st through June 30th with the payment due prior to August 31st.
9. We understand that retirees from our agency may also be eligible for this plan once we confirm our initial enrollment into the Plan.
10. We have read and agree to the complete Employer Terms of the Plan.
11. We understand that information regarding this benefit can be located at www.psprs.com.

❒ Our agency does not wish to offer the Cancer Insurance Program to our eligible employees this fiscal year. We understand that if we decline the Plan, it will not be available to our active members, or our retirees.

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

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