PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN

3010 East Camelback Road, Suite 200
Phoenix, Arizona 85016-4416
www.psprs.com
(602) 255-5575

Form ER-SUB
01/2023

Fax (602) 296-2370
OR scan/email to
Insurancegrp@psprs.com

EMPLOYER REQUEST FOR SUBSIDY

Revised ☐

SECTION 1 – PRINT Member Information

SSN	Last Name	First Name, Middle Initial

Select ONE	REQUIRED Effective Date	REQUIRED – Select Item 1 OR 2 below
☐ New Retiree/Survivor ☐ Open Enrollment ☐ Return to Work Retiree ☐ Qualifying Life Event ☐ Medicare Change ☐ Terminate Coverage	Month / Day/ Year Employer Name	1) ☐ Retiree/Cobra Insurance & select ONE below ☐ Deduct medical / dental premiums below from retirement check, **OR** ☐ Send subsidy to employer (aka "direct bill") OR 2) ☐ Return to Work Retiree - Subsidy will be sent to the employer ("direct bill"). *Also, complete the following (and include approved board minutes)*: Date of Hire: Position Title: Indicate if designated position of: ☐ PSPRS, ☐ CORP, ☐ EORP, OR ☐ ASRS
Type of Coverage	Retired from	
☐ Single, OR ☐ Dependent / Family	☐ PSPRS, CORP, OR EORP AND / OR ☐ ASRS	

SECTION 2 - MEDICAL

☐ Add New or Change Coverage	**Monthly** Member Cost:		Carrier Name:	
☐ Term or Decline Coverage	Dependent Cost:		Medical code (if known):	
☐ NO change in coverage; leave as is	Total Premium: $	$0.00		

SECTION 3 - DENTAL

☐ Add New or Change Coverage	**Monthly** Member Cost:		Carrier Name:	
☐ Term or Decline Coverage	Dependent Cost:		Dental code (if known):	
☐ NO change in coverage; leave as is	Total Premium: $	$0.00		

SECTION 4 – DEPENDENT INFORMATION FOR MEDICAL AND/OR DENTAL

Last Name, First	Relationship	SSN	DOB	Sex

Notes	

SECTION 5 – PRINT Employer Contact Name	Email	Phone Number	Date

Submit

Return the completed form by the 10th of the month to be processed the same month.