2025 DENTAL COVERAGE ENROLLMENT FORM

Public Safety Personnel Retirement System

ATTN: HEALTH INSURANCE
3010 East Camelback Road #200
Phoenix, AZ 85016

How to Complete this Enrollment Form

Complete a PSPRS Enrollment Form if you are enrolling for the first time, electing new coverage, or changing your existing coverage. Submission of a properly completed Enrollment Form is required to enroll in a dental plan. Please complete the Enrollment Form as outlined below:

Step 1

- Effective Date: Fill in the month that you need the insurance coverage to begin. Effective date of your coverage will be the first of the month following receipt of the Enrollment Form unless a future date is provided. January 1, 2025 is the effective date for the 2025 Open Enrollment period.

- Check boxes that apply to you:
  - Reason for Enrollment Form
  - Status

Step 2

- Provide your social security number, name, address, etc. If you want your mail sent to a different mailing address than your primary residence, complete the mailing address line.

Step 3

- Check the box of the dental plan you are electing. You can only select one option.

Step 4

- List yourself and all eligible dependents that you are enrolling in the dental plan.

- If you are electing the Cigna DHMO, you must provide a Dentist Office ID number or a dentist will be automatically assigned to you. If you are unsure what to include, visit **Cigna.com/ASRS** to search for dentists in the **Cigna Dental Care Access Plus** network or by calling 800-244-6224.

Step 5

- Sign and date the Enrollment Form. Signature must be from either the retiree, disabled member or a surviving dependent. The enrollment form cannot be dated more than 90 days prior to the requested effective date. Open Enrollment forms must be signed, dated, and submitted between November 1 and November 30.

- If you are enrolling mid-year (a time outside of the Open Enrollment period) in a dental insurance plan, you are required to provide proof within 31 days of the qualifying life event that you are experiencing. If you are unsure on what to provide, you may contact PSPRS Member Services at 602-255-5575.

- Email, fax, dropoff, or mail your Enrollment Form to:

  Public Safety Personnel Retirement System
  ATTN: HEALTH INSURANCE
  3010 East Camelback Road #200
  Phoenix, AZ 85016
  insurancegrp@psprs.com
  Fax: (602) 296-2370

NOTE: If you are terminating your current dental coverage, please send a letter in writing to PSPRS, with the retiree, disabled member, or surviving spouse's Social Security number and your signature.

2025 DENTAL ENROLLMENT FORM

Public Safety Personnel Retirement System

ATTN: HEALTH INSURANCE
3010 East Camelback Road #200
Phoenix, AZ 85016

Effective Date: 1st of _____, 2025 *(MONTH)*	**You are:** ☐ Retired ☐ Disabled ☐ Surviving Dependent

Reason for Enrollment Form:

☐ **Open Enrollment** *(Applicable to ASRS Open Enrollment only)* ☐ **Qualifying Life Event:** *(as defined by ASRS)* _____

☐ **New Retiree - Retirement Date:** ___/___/_____

Disclosure of your Social Security number is mandated by Section 6109 of the Internal Revenue Code. The PSPRS will use Social Security numbers only to obtain information about an individual's PSPRS account and to inform the Internal Revenue Service of distributions and withholdings.

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	DATE OF BIRTH

PRIMARY RESIDENCE STREET ADDRESS	CITY	STATE	ZIPCODE

MAILING ADDRESS *(if different than above)*	CITY	STATE	ZIPCODE

PRIMARY PHONE NUMBER	COUNTY OF RESIDENCE	IS THIS A CHANGE OF ADDRESS: ☐ Yes ☐ No	GENDER: ☐ Male ☐ Female	CURRENT MARITAL STATUS: ☐ Single ☐ Married

CURRENT EMAIL ADDRESS	NAME OF FORMER EMPLOYER	MEMBER OF: ☐ ASRS ☐ PSPRS ☐ CORP ☐ EORP ☐ ORP

	Single	**Family** *(Single +1)*	**Family** *(Single +2 or more)*	**Dentist Office ID #** *(6 digit Dentist Office ID number can be found in the directory)*
DELTA DENTAL PPO - NATIONWIDE COVERAGE				
Delta Dental High Plan Option	☐ $ 38.67 a month	☐ $ 77.17 a month	☐ $ 109.20 a month	*Not Applicable*
Delta Dental Low Plan Option	☐ $ 17.95 a month	☐ $ 37.95 a month	☐ $ 69.47 a month	*Not Applicable*
CIGNA DHMO - SELECT STATES (EXCLUDES AK, ME, MT, NH, NM, ND, PR, SD, VI, VT, AND WY)				
Cigna DHMO	☐ $ 10.24 a month	☐ $ 16.79 a month	☐ $ 25.94 a month	

Please list all eligible individuals to be enrolled in dental coverage.

	Last Name	First Name	MI	Sex (M/F)	Social Security Number	Date of Birth
Primary Member						
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						

I request enrollment in the Arizona State Retirement System (ASRS) Retiree Dental Program and verify the information that I've provided is true and accurate. I hereby acknowledge that I cannot be enrolled in this plan and another group plan simultaneously. I hereby authorize premium deductions to be taken from my monthly retirement check if sufficient to cover the premium; otherwise, I understand I will be required to make premium payments directly to the insurance carrier. I understand that this enrollment form must be received by PSPRS prior to the requested effective date of coverage. I understand that if I'm changing coverage due to a temporary address change, it is my responsibility to notify PSPRS of my impending return.

Primary Member Signature:_____ **Date:** _____