2025 MEDICAL 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 medical 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 completed Enrollment Form unless a future date is provided or the Qualify Life Event requires an alternate date. 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 medical plan you are electing. You can only select one option.

  Please note: The **Group Medicare Advantage HMO** is only available to members residing in the state of Arizona, including when selected as part of a combination plan.

Step 4

- List yourself and all eligible dependents that you are enrolling in the medical plan.
- Group Medicare Advantage HMO plan only: List the names of the persons enrolling in this plan in the Covered Person Name box; indicate the name(s) of the Primary Care Physician(s), The Primary Care Physician's ID Number, and the Group Medicare Advantage HMO Network(s) you are choosing. If you are unsure what to include, you can find the Group Medicare Advantage HMO Provider directory at retiree.uhc.com/ASRS or you can call 844-876-6161.

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 in a Medicare plan, please provide a copy of your Medicare card or an award letter showing you are eligible for Medicare Parts A and B.
- If you are enrolling mid-year (a time outside of the Open Enrollment period) in a medical 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

Step 6

- If you are enrolling in a Medicare plan, please complete the questions on page 4 for each individual enrolling in a Medicare plan. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

NOTE: If you are terminating your current medical coverage, please send a letter in writing to PSPRS, with the retiree, disabled member or surviving spouse's social security number and your signature. If you and/or your dependents are terminating a Medicare plan, please include all covered members' signatures.

2025 MEDICAL COVERAGE 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 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:	GENDER:	CURRENT MARITAL STATUS:
		☐ Yes ☐ No	☐ Male ☐ Female	☐ Single ☐ Married

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

MEDICAL INSURANCE PLANS - by UnitedHealthcare *(Please choose only one plan from all options on this form)*

NON-MEDICARE PLANS *(You and your dependent(s) **DO NOT** have Medicare Part A and B)*

	Single	Family *(Single +1)*	Family *(Single +2 or more)*
Choice Premier *(**Nationwide** In-Network Only Coverage)*	☐ $ 1,290.00 a month	☐ $ 2,580.00 a month	☐ $ 3,612.00 a month
Choice Value *(**Nationwide** In-Network Only Coverage)*	☐ $ 886.00 a month	☐ $ 1,772.00 a month	☐ $ 2,481.00 a month
Choice Economy *(**Nationwide** In-Network Only Coverage)*	☐ $ 660.00 a month	☐ $ 1,320.00 a month	☐ $ 1,848.00 a month

MEDICARE PLANS *(You and your dependent(s) **HAVE** Medicare Part A and B)*

	One Person	Two People	Three People
Group Medicare Advantage HMO *(**Arizona** In-Network Coverage Only)*	☐ $ 96.38 a month	☐ $ 192.76 a month	☐ $ 289.14 a month
Group Medicare Advantage PPO *(**Nationwide** In & Out-of-Network Coverage)*	☐ $ 199.26 a month	☐ $ 398.52 a month	☐ $ 597.78 a month

COMBINATION FAMILY PLANS

(You, or your dependent(s), are a combination of non-Medicare and Medicare eligible)

- *Combination Plans including the **Group Medicare Advantage HMO** are only available to members residing in the **state of Arizona**.*
- *Combination Plans including the **Group Medicare Advantage PPO** are available to members **nationwide**.*
- *All non-Medicare plans are available to members nationwide.*
- *Not all potential family scenarios are included in the chart below. Contact the ASRS if you feel your scenario is not represented.*

Combo Plans for only 1 person with Medicare	1 person with Medicare, & 1 without Medicare	1 person with Medicare, & 2+ without Medicare
Group Medicare Advantage **HMO** with **Choice Premier**	☐ $ 1,386.38 a month	☐ $ 2,676.38 a month
Group Medicare Advantage **HMO** with **Choice Value**	☐ $ 982.38 a month	☐ $ 1,868.38 a month
Group Medicare Advantage **HMO** with **Choice Economy**	☐ $ 756.38 a month	☐ $ 1,416.38 a month
Group Medicare Advantage **PPO** with **Choice Premier**	☐ $ 1,489.26 a month	☐ $ 2,779.26 a month
Group Medicare Advantage **PPO** with **Choice Value**	☐ $ 1,085.26 a month	☐ $ 1,971.26 a month
Group Medicare Advantage **PPO** with **Choice Economy**	☐ $ 859.26 a month	☐ $ 1,519.26 a month

COMBINATION FAMILY PLANS *(continued)*

Combo Plans for 2 people with Medicare	**2 people with Medicare, & 1 without Medicare**	**2 people with Medicare, & 2+ without Medicare**
Group Medicare Advantage **HMO** with **Choice Premier**	☐ $ 1,482.76 a month	☐ $ 2,772.76 a month
Group Medicare Advantage **HMO** with **Choice Value**	☐ $ 1,078.76 a month	☐ $ 1,964.76 a month
Group Medicare Advantage **HMO** with **Choice Economy**	☐ $ 852.76 a month	☐ $ 1,512.76 a month
Group Medicare Advantage **PPO** with **Choice Premier**	☐ $ 1,688.52 a month	☐ $ 2,978.52 a month
Group Medicare Advantage **PPO** with **Choice Value**	☐ $ 1,284.52 a month	☐ $ 2,170.52 a month
Group Medicare Advantage **PPO** with **Choice Economy**	☐ $ 1,058.52 a month	☐ $ 1,718.52 a month

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

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

ATTENTION: If you and/or your dependents are enrolling in the **UnitedHealthcare Group Medicare Advantage HMO**, you will need to select a Primary Care Physician. **If you do not list a medical doctor, one will be automatically assigned to you.**

Name of Covered Person	Physician Name & Physician ID number *(Group Medicare Advantage HMO only)*	Network Name *(Group Medicare Advantage HMO only)*

I request enrollment in the Arizona State Retirement System (ASRS) Retiree Group Insurance 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. If either I or my dependent(s) are enrolled in Medicare and are enrolling in the Group Medicare Advantage HMO or the Group Medicare Advantage PPO Plan with UnitedHealthcare MedicareRx for Groups Prescription Drug Coverage, 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:** ______________

If you are enrolling in a Medicare plan, please complete the questions below for each individual enrolling in a Medicare plan. **All fields on this page are optional. You cannot be denied coverage if you choose not to answer.**

1. Primary Member *(For Medicare Plan Enrollment Only)*

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ **I choose not to answer.**
- ☐ Yes, Cuban
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ **I choose not to answer.**
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White

2. Spouse *(For Medicare Plan Enrollment Only)*

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ **I choose not to answer.**
- ☐ Yes, Cuban
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ **I choose not to answer.**
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White

3. Dependent *(For Medicare Plan Enrollment Only)*

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ **I choose not to answer.**
- ☐ Yes, Cuban
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ **I choose not to answer.**
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White