2026 Dental Enrollment Form

Public Safety Personnel Retirement System

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

How to Complete this Enrollment Form

Complete this 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 completed Enrollment Form unless a future date is provided. **January 1, 2026** is the effective date for the 2026 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

- 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 call **800-244-6224.**

Step 4

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

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.
- Only one form of submission is required.
  Email, fax, drop-off, or mail your enrollment form to:

Public Safety Personnel Retirement System
Attn: Health Insurance
3010 East Camelback Rd. #200
Phoenix, AZ 85016

Email: 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.

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3010 East Camelback Rd. #200
Phoenix, AZ 85016

Effective Date: 1st of (month)_____, 2026

Status:	**Reason for Enrollment:**
☐ Retired	☐ Open Enrollment *(applicable to ASRS Open Enrollment Only)*
☐ Disabled	☐ Qualifying Event (*as defined by ASRS)*
☐ Surviving Dependent	☐ New Retiree *Retirement Date:*_____/_____/_____

Disclosure of your Social Security number is mandated by § 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	Zip Code
Mailing Address *(if different from above)*	City	State	Zip Code

Primary Phone Number	County of Residence	Is this a change of address? Yes ☐ No ☐	Gender: Male ☐ Female ☐	Marital Status: Single ☐ Married ☐

Email Address	Former Employer	Member of: ASRS ☐ PSPRS ☐ CORP ☐ EORP ☐ ORP ☐

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

	Single	**Family** Single + 1	**Family** Single + 2 or more	**Dentist Office ID #** This 6-digit number can be found in the directory
Delta Dental PPO - Nationwide Coverage				
Delta Dental High Plan Option	☐ $38.67 / month	☐ $77.17 / month	☐ $109.20 / month	Not applicable
Delta Dental Low Plan Option	☐ $17.95 / month	☐ $37.95 / month	☐ $69.47 / month	Not applicable
Cigna DHMO - Select states (excludes AK, ME, MT, NH, NM, ND, PR, SD, VI, VT, and WY)				
Cigna DHMO	☐ $10.92 / month	☐ $17.91 / month	☐ $27.68 / month	

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 the 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 the PSPRS of my impending return.

Primary Member Signature_____ **Date**_____