

2026 Medical Enrollment Form

**Public Safety Personnel
Retirement System**

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

How to Complete this 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 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. January 1, 2026 is the effective date for the 2026 Open Enrollment.

Check boxes that apply to you:

- Reason for Enrollment Form
- Status

Step 2

Information

- 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

Enrollees

- 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 4

Plan Selection

- 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 5

Sign, Date, and Return

- 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 other than 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.
- **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

Step 6

Optional Questions

- 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 optional. 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.

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Coverage Effective Date: 1st of (month) _____, 2026	Status: <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Surviving Dependent
Reason for Enrollment:	
<input type="checkbox"/> Open Enrollment (<i>ASRS Open Enrollment Only</i>) <input type="checkbox"/> Qualifying Event (<i>defined by ASRS</i>) <input type="checkbox"/> 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 (<i>if different from above</i>)		City	State	Zip Code
Primary Phone Number	County of Residence	Is this a change of address? Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>
Email Address	Former Employer		Member of: ASRS <input type="checkbox"/> PSPRS <input type="checkbox"/> CORP <input type="checkbox"/> EORP <input type="checkbox"/> ORP <input type="checkbox"/>	

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

Group Medicare Advantage HMO only: list your Primary Care Physician

Attention: If you and/or your dependents are enrolling in the **Group Medicare Advantage HMO**, you must select a Primary Care Physician. **If you do not list a medical doctor, one will be automatically assigned to you.** You can find the Group Medicare Advantage HMO Provider directory at retiree.uhc.com/ASRS or call 844-876-6161.

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

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**Check the box of the UnitedHealthcare Medical Insurance Plan you are electing.
Choose only one option on this page.**

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)	<input type="checkbox"/> \$1,397.00 /month	<input type="checkbox"/> \$2,794.00 /month	<input type="checkbox"/> \$3,912.00 /month
Choice Value (Nationwide In-Network Only Coverage)	<input type="checkbox"/> \$886.00 /month	<input type="checkbox"/> \$1,772.00 /month	<input type="checkbox"/> \$2,481.00 /month
Choice Economy (Nationwide In-Network Only Coverage)	<input type="checkbox"/> \$660.00 /month	<input type="checkbox"/> \$1,320.00 /month	<input type="checkbox"/> \$1,848.00 /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 Only Coverage)	<input type="checkbox"/> \$131.83 /month	<input type="checkbox"/> \$263.66 /month	<input type="checkbox"/> \$395.49 /month
Group Medicare Advantage PPO (Nationwide In & Out-of-Network Coverage)	<input type="checkbox"/> \$234.30 /month	<input type="checkbox"/> \$468.60 /month	<input type="checkbox"/> \$702.90 /month

Combination Family Plans - You and your dependent(s) are a combination of Medicare and Non-Medicare eligible		
<ul style="list-style-type: none"> 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 PSPRS if you feel your scenario is not represented. 		
Combination Family Plans for <u>only 1</u> person with Medicare:	1 person with Medicare & 1 person <u>without</u> Medicare	1 person with Medicare & 2 or more <u>without</u> Medicare
Group Medicare Advantage HMO with Choice Premier	<input type="checkbox"/> \$1,528.83 /month	<input type="checkbox"/> \$2,925.83 /month
Group Medicare Advantage HMO with Choice Value	<input type="checkbox"/> \$1,017.83 /month	<input type="checkbox"/> \$1,903.83 /month
Group Medicare Advantage HMO with Choice Economy	<input type="checkbox"/> \$791.83 /month	<input type="checkbox"/> \$1,451.83 /month
Group Medicare Advantage PPO with Choice Premier	<input type="checkbox"/> \$1,631.30 /month	<input type="checkbox"/> \$3,028.30 /month
Group Medicare Advantage PPO with Choice Value	<input type="checkbox"/> \$1,120.30 /month	<input type="checkbox"/> \$2,006.30 /month
Group Medicare Advantage PPO with Choice Economy	<input type="checkbox"/> \$894.30 /month	<input type="checkbox"/> \$1,554.30 /month
Combination Family Plans for <u>2</u> people with Medicare:	2 people with Medicare & 1 person <u>without</u> Medicare	2 people with Medicare & 2 or more <u>without</u> Medicare
Group Medicare Advantage HMO with Choice Premier	<input type="checkbox"/> \$1,660.66 /month	<input type="checkbox"/> \$3,057.66 /month
Group Medicare Advantage HMO with Choice Value	<input type="checkbox"/> \$1,149.66 /month	<input type="checkbox"/> \$2,035.66 /month
Group Medicare Advantage HMO with Choice Economy	<input type="checkbox"/> \$923.66 /month	<input type="checkbox"/> \$1,583.66 /month
Group Medicare Advantage PPO with Choice Premier	<input type="checkbox"/> \$1,865.60 /month	<input type="checkbox"/> \$3,262.60 /month
Group Medicare Advantage PPO with Choice Value	<input type="checkbox"/> \$1,354.60 /month	<input type="checkbox"/> \$2,240.60 /month
Group Medicare Advantage PPO with Choice Economy	<input type="checkbox"/> \$1,128.60 /month	<input type="checkbox"/> \$1,788.60 /month

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 Group Prescription Drug Coverage, 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 _____
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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:

- | | |
|---|---|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, Mexican, Mexican-American, Chicano/a | <input type="checkbox"/> Yes, Puerto Rican |
| <input type="checkbox"/> I choose not to answer. | <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |

• What is your race? Select all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> I choose not to answer. | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> White |

2. Spouse - for Medicare Plan Enrollment Only

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

- | | |
|---|---|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, Mexican, Mexican-American, Chicano/a | <input type="checkbox"/> Yes, Puerto Rican |
| <input type="checkbox"/> I choose not to answer. | <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |

• What is your race? Select all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> I choose not to answer. | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> White |

3. Dependent - for Medicare Plan Enrollment Only

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

- | | |
|---|---|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, Mexican, Mexican-American, Chicano/a | <input type="checkbox"/> Yes, Puerto Rican |
| <input type="checkbox"/> I choose not to answer. | <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |

• What is your race? Select all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> I choose not to answer. | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> White |