# PS/CORP CANCER INSURANCE POLICY RE-ENROLLMENT FORM

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**01/2026**

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## CANCER INSURANCE RE-ENROLLMENT FORM

| **PRINT Full Name** | **SSN** | **Date of Birth** *(MM/DD/YYYY)* |
|---|---|---|
| | | |

| **Address** | **City, State and ZIP** |
|---|---|
| | |

| **Primary Phone** | **Email Address** |
|---|---|
| | |

The Cancer Insurance Program allows additional coverage for eligible PSPRS and CORP retirees who have exhausted their earned coverage period pursuant to A.R.S. § 38-644. CORP employers must have elected to participate in this program for members to elect to receive coverage during employment and retirement.

1. I understand that PSPRS will review my service record and Cancer Insurance Policy coverage history to make a final determination concerning my eligibility for additional coverage.
2. I understand that upon receipt of this registration form and affirmative determination of my eligibility PSPRS will invoice me for additional cancer insurance coverage.
3. I understand that annual premium amounts are set by the PSPRS Board of Trustees.
4. I understand that my coverage is effective upon premium payment.
5. I understand that a full annual premium of $185.00 will be deducted from my pension in July of each year going forward and that I have 180 days from then to request a refund, but doing so will end coverage and eligibility for future coverage.
6. I understand that I have until January 1, 2027 (for fiscal year 2026/2027), or within the timeframe of invoice to re-enroll in coverage.
7. I have reviewed and understand this benefit, including eligibility requirements and coverage limitations, as provided at www.psprs.com.

☐ **I wish to re-enroll in the Cancer Insurance Program for additional coverage and agree to the terms listed above. This form can be mailed, faxed or emailed to PSPRS.**

**Retiree signature** *(must sign)* ______________________ **Date** *(MM/DD/YYYY)* ____________