Public Safety Personnel Retirement System

2027 Medical Enrollment Form

Or enroll online at https://psprs.com/members/

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

PSPRS now offers a secure, online method to manage your enrollment through STARS Member Self-Service link: www.psprs.com/members/.

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 medical plan. Please complete the Enrollment Form as outlined below:

1. Effective Date, Status, and Reason for Enrolling

- **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, 2027** is the effective date for the 2027 Open Enrollment period.
- **Check boxes** that apply to you:
  - Reason for Enrollment
  - Status

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.

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 people 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 do not list a Primary Care Physician, one will be automatically assigned to you.** 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.

4. Plan Selection

- **Check the box** of the medical plan you are electing. You can select only **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.

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 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 of what to provide, you may contact PSPRS Member Services at 602-255-5575.
- **Only one form of submission is required.**
  Mail, drop off, or email your Enrollment Form to:
  Public Safety Personnel Retirement System
  Attn: Health Insurance
  3010 East Camelback Rd. #200
  Phoenix, AZ 85016
  Email: insurancegrp@psprs.com

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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3010 East Camelback Rd. #200
Phoenix, AZ 85016

Effective Date: 1st of (month) _____, 2027	**Status:** ☐ Retired ☐ Disabled ☐ Surviving Dependent

Reason for Enrollment: ☐ Open Enrollment (applicable to ASRS Open Enrollment only) ☐ New Retiree (Retirement Date): _____/_____/_____

☐ Qualifying Event - List qualifying event here (as defined by ASRS):

_____

Social Security Number*	Date of Birth		
Last Name	First Name		M.I.
Primary Residence Street Address	City	State	Zip Code
Mailing Address (if different from above)	City	State	Zip Code
Primary Phone Number	County of Residence	Email Address	
Is this a change of address? Yes ☐ No ☐	Gender: Male ☐ Female ☐	Status: Married ☐ Single ☐	
Former Employer	Member of: ASRS ☐ PSPRS ☐ CORP ☐ EORP ☐ ORP ☐		

* 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.

	Last Name	**First Name**	**M.I.**	**Sex (M/F)**	**Social Security No.**	**Date of Birth**
Primary Member						
Spouse						
Dependent						
Dependent						
Dependent						

For Group Medicare Advantage HMO only: list your Primary Care Physician Information

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

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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 EPO Select (Nationwide In-Network Only Coverage)	☐ $1,512.00 /month	☐ $3,024.00 /month	☐ $4,234.00 /month
Choice EPO Basic (Nationwide In-Network Only Coverage)	☐ $826.00 /month	☐ $1,652.00 /month	☐ $2,313.00 /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)	☐ $131.83 /month	☐ $263.66 /month	☐ $395.49 /month
Group Medicare Advantage PPO (**Nationwide** In & Out-of-Network Coverage)	☐ $234.30 /month	☐ $468.60 /month	☐ $702.90 /month

Combination Family Plans - You and your dependent(s) are a mix of Medicare and Non-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 PSPRS if you feel your scenario is not represented.

Combination Family Plans for only 1 person with Medicare:	1 person with Medicare & 1 person without Medicare	1 person with Medicare & 2 or more without Medicare
Group Medicare Advantage **HMO** with Choice **EPO Select**	☐ $1,643.83 /month	☐ $3,155.83 /month
Group Medicare Advantage **HMO** with Choice **EPO Basic**	☐ $957.83 /month	☐ $1,783.83 /month
Group Medicare Advantage **PPO** with Choice **EPO Select**	☐ $1,746.30 /month	☐ $3,258.30 /month
Group Medicare Advantage **PPO** with Choice **EPO Basic**	☐ $1,060.30 /month	☐ $1,886.30 /month
Combination Family Plans for 2 people with Medicare:	2 people with Medicare & 1 person without Medicare	2 people with Medicare & 2 or more without Medicare
Group Medicare Advantage **HMO** with Choice **EPO Select**	☐ $1,775.66 /month	☐ $3,287.66 /month
Group Medicare Advantage **HMO** with Choice **EPO Basic**	☐ $1,089.66 /month	☐ $1,915.66 /month
Group Medicare Advantage **PPO** with Choice **EPO Select**	☐ $1,980.60 /month	☐ $3,492.60 /month
Group Medicare Advantage **PPO** with Choice **EPO Basic**	☐ $1,294.60 /month	☐ $2,120.60 /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 Group Medicare Part D 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.

Don't forget to sign and include today's date before mailing your form.

Primary Member Signature _____ **Today's Date** _____