



## Instructions

### Step 1: Complete the form fully and legibly

1. If you have more dependents than form space allows, attach an additional page.
2. If evidence of good health and underwriting approval are required for ASU Life and AD&D, Securian will mail a form and instructions to you.
3. Complete and submit the form even if you are waiving all coverage options.
4. Incomplete submissions may delay processing and result in retroactive deductions.

### Step 2: Required documents

1. If changing benefits due to a qualified life event, you must provide documentation that supports your changes. Learn more: [cfo.asu.edu/qualified-life-events](https://cfo.asu.edu/qualified-life-events)
2. If enrolling a spouse or eligible dependents:
  - a. You must provide documentation that demonstrates eligibility, including but not limited to: marriage certificate, birth certificate or passport.
  - b. Social Security numbers (SSNs) are required for dependents enrolled in medical, dental and/or vision. If your dependent is not eligible for a SSN due to their visa status, you must provide substantiating documentation, including but not limited to: a legal document showing visa status.
  - c. Dependent names and SSNs must match their Social Security card. The IRS may assess a \$50 penalty for incorrect dependent data.
  - d. Learn more at [cfo.asu.edu/eligibility-and-enrollment](https://cfo.asu.edu/eligibility-and-enrollment).
3. All required documentation must be translated to English.

**Important:** Do not delay submitting this form Benefits Enrollment/Change form if you are waiting to receive required supporting documentation.

### Step 3: Submit your completed, signed form within 30 calendar days of hire date, eligibility date or qualified life event effective date

Submit the completed, signed form (pages 2-5 only) and any required documentation by one of the following secure methods:

1. **Fax to:** Confidential Benefits E-fax 480-993-0007
2. **Email to:** [HumanResources-Benefits@exchange.asu.edu](mailto:HumanResources-Benefits@exchange.asu.edu)
  - You must use your ASU email account (asu.edu).
  - You must type [SECURE] in the subject line, including the square brackets.
  - Do not forward or copy others on the email.
  - This box does not send replies or responses to inquiries.
3. **Mail to:**  
Arizona State University  
Attn: Benefits  
P.O. Box 871304  
Tempe, AZ 85287-1304

### Step 4: Verify your coverage

1. Allow 7-10 business days for processing.
2. Log into [My ASU](#) using your ASURITE user ID and password.
  - a. Go to My Employment > Benefits > My Benefits Summary.
  - b. Change the effective date to your coverage effective date and click "Go."
3. For coverage effective date information, visit [cfo.asu.edu/benefits-and-mandatory-retirement-effective-dates](https://cfo.asu.edu/benefits-and-mandatory-retirement-effective-dates).
4. For pay period start dates, view Payroll and Payday Calendars at [cfo.asu.edu/payroll-calendars](https://cfo.asu.edu/payroll-calendars).
5. Health care ID cards will be mailed to your home within 2-3 weeks after your enrollments are processed.
6. Report all discrepancies immediately to the Office of Human Resources Employee Service Center at 855-278-5081 or [HRESC@asu.edu](mailto:HRESC@asu.edu).

### Additional information

- Learn about your benefits options at [cfo.asu.edu/benefits](https://cfo.asu.edu/benefits)
- If your covered dependents are employed by ASU, The University of Arizona, Northern Arizona University, the Arizona Board of Regents or the State of Arizona, you and your dependents can only be covered on the same plans with one employer. **Dual coverage is prohibited.**
- Plan provisions may require that you are actively at work on the effective date of coverage. Learn more: [cfo.asu.edu/benefits-and-mandatory-retirement-effective-dates](https://cfo.asu.edu/benefits-and-mandatory-retirement-effective-dates)

**Need assistance?** Office of Human Resources Employee Service Center | 855-ASU-5081 (855-278-5081) | [HRESC@asu.edu](mailto:HRESC@asu.edu)

**Disclaimer:** The information contained in this form is provided to allow you to make benefit elections. If there are any discrepancies between this information and official documents, official documents will govern. The State of Arizona, Arizona Board of Regents and Arizona State University reserve the right to modify any of its plans, in whole or part, at any time.

**Fax pages 2-5 to 480-993-0007; keep page 1 for future reference.**



# 2024 Benefits Enrollment/Change form

## Section A: Employee Identification Information

Last Name, First Name, M.I.:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:	Hire/Eligibility Date:
SSN (Required):		ASU Employee ID (10 Digit):		<input type="checkbox"/> Single <input type="checkbox"/> Married
Street Address, City, State, Zip Code:				
Work Phone:	Home Phone:	Email Address:		

## Section B: Dependent Information (Attach separate sheet for additional dependents if applicable)

1	Last Name, First Name, M.I. as it appears on Social Security card:	Birth Date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check one: <input type="checkbox"/> Add
	SSN (Required):	ASU Employee ID (10 Digit):			<input type="checkbox"/> Remove
	Relationship (check one): <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Select Plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
2	Last Name, First Name, M.I. as it appears on Social Security card:	Birth Date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check one: <input type="checkbox"/> Add
	SSN (Required):	ASU Employee ID (10 Digit):			<input type="checkbox"/> Remove
	Relationship (check one): <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Select Plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
3	Last Name, First Name, M.I. as it appears on Social Security card:	Birth Date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check one: <input type="checkbox"/> Add
	SSN (Required):	ASU Employee ID (10 Digit):			<input type="checkbox"/> Remove
	Relationship (check one): <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Select Plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			

## Section C: Enrollment Request – Check one box in 1 or 2

1	<input type="checkbox"/> <b>New Hire</b> I have not previously worked for ASU	<input type="checkbox"/> <b>Rehire</b> I previously worked for ASU in a <b>benefits-eligible position</b> and had a break in service of: <input type="checkbox"/> 30 days or less <input type="checkbox"/> More than 30 days but less than 12 months <input type="checkbox"/> 12 or more months	<input type="checkbox"/> <b>Newly Eligible</b> I have been working for ASU and recently became eligible to elect benefits	<input type="checkbox"/> <b>Transfer/Re-employed from another Arizona university or state agency</b> Check One: NAU    UA    Arizona state agency: Last Day of Employment: Arizona university or state agency contact name: Phone: Email:				
	2 <input type="checkbox"/> <b>Qualified Life Event (QLE) Date Event:</b> <span style="float: right;"><b>Supporting documentation required</b></span>							
<b>Enroll/Add</b>		<b>Remove</b>		<b>Miscellaneous</b> <input type="checkbox"/> Cancel Dependent Life <input type="checkbox"/> Cancel Short-term Disability <input type="checkbox"/> Significant change in day care expense or provider <input type="checkbox"/> Non-payment of premiums during leave <input type="checkbox"/> Eligible for LTD benefits <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other/please explain:				
Employee: <input type="checkbox"/> Change in legal marital status <input type="checkbox"/> Loss of eligibility or other coverage <input type="checkbox"/> Returns from unpaid leave (only if benefits were voluntarily cancelled at start of leave) <input type="checkbox"/> Moves into USA		Employee: <input type="checkbox"/> Change in legal marital status <input type="checkbox"/> Gains other coverage <input type="checkbox"/> Begins unpaid leave <input type="checkbox"/> Moves from USA <input type="checkbox"/> Death						
Spouse: <input type="checkbox"/> Change in legal marital status <input type="checkbox"/> Loss of eligibility or other coverage <input type="checkbox"/> Moves into USA		Spouse: <input type="checkbox"/> Change in legal marital status <input type="checkbox"/> Gains other coverage <input type="checkbox"/> Moves from USA <input type="checkbox"/> Death						
Child(ren): <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Placement for adoption or Foster care <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Loss of eligibility or other coverage <input type="checkbox"/> Moves into USA <input type="checkbox"/> Qualified Medical Child Support Order		Child(ren): <input type="checkbox"/> Reaches maximum age <input type="checkbox"/> Gains other coverage <input type="checkbox"/> Moves from USA <input type="checkbox"/> Death						
<b>For HR Use Only</b>	Date Received	Effective Date	Reviewed By	Cobra QLE? <input type="checkbox"/> Yes <input type="checkbox"/> No	PS Entered Date	PS Entered By	ADOA Entered Date	ADOA Entered By



# 2024 Benefits Enrollment/Change form

Section D: Health Plans			
1	<b>Medical Plans</b> (Check one) <input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<b>Coverage Level</b> (Check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Adult <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Family	<b>Provider</b> (Check one) <b>Triple Choice Plan - TCP</b>
			<b>High Deductible Health Plan w/HSA</b> BCBS UnitedHealthcare <b>To enroll in the Health Savings Account, go to Section F.</b>
2	<b>Dental Plans</b> (Check one) <input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<b>Coverage Level</b> (Check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Adult <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Family	<b>Provider</b> (Check one) <b>PPO</b>
			<b>DHMO</b> United Healthcare Solstice Dental Not available in: AL, AK, AR, DE, HI, ID, IA, LA, ME, MS, MT, NE, NH, ND, OK, RI, SD, VT, WV, WY, Guam, Puerto Rico, and US Virgin Islands.
3	<b>Vision Plans</b> (Check one) <input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<b>Coverage Level</b> (Check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Adult <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Family	<b>Provider</b> Avesis

Section E: Flexible Spending Accounts (FSA)			
Elect calendar-year annual amounts, not per-pay-period amounts			
1	<b>Health Care FSA</b>		
	<input type="checkbox"/> Enroll - Annual election: \$ Minimum \$100	<input type="checkbox"/> Change annual election, From: \$ To: \$	<input type="checkbox"/> Decline <input type="checkbox"/> No Change
2	<b>Child/Adult Day Care FSA</b>		
	<input type="checkbox"/> Enroll - Annual election: \$ Minimum \$100	<input type="checkbox"/> Change annual election, From: \$ To: \$	<input type="checkbox"/> Decline <input type="checkbox"/> No Change
3	<b>Limited Health Care FSA</b> (Available only to HDHP medical plan participants)		
	<input type="checkbox"/> Enroll - Annual election: \$ Minimum \$100	<input type="checkbox"/> Change annual election, From: \$ To: \$	<input type="checkbox"/> Decline <input type="checkbox"/> No Change

Section F: Health Savings Account (HSA) (Available only to HDHP medical plan participants) Elect a calendar-year annual amount, not a per-pay-period amount			
<input type="checkbox"/> Enroll - Annual election: \$	<input type="checkbox"/> Change annual election, From: \$ To: \$	<input type="checkbox"/> Decline <input type="checkbox"/> No Change	

Section G: Short-term Disability Insurance (STD)		
Select only one STD provider (Unum or MetLife)		
<b>STD Plan</b> (Check one) <input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<b>Provider</b> (Check one provider only)	
	<b>Unum</b> <input type="checkbox"/> Option A (Maximum Weekly Benefit: \$750) <input type="checkbox"/> Option B (Maximum Weekly Benefit: \$1,500) <input type="checkbox"/> Option C (Maximum Weekly Benefit: \$2,000) <i>Weekly Benefit: 70% of covered salary subject to maximums</i> <b>Note:</b> Unum enrollment includes a \$5,000 group life and AD&D policy. To designate beneficiaries, complete a <a href="#">Unum Beneficiary Designation form</a> and fax it to 480-993-0007.	<b>MetLife</b> <input type="checkbox"/> MetLife (Maximum Weekly Benefit: \$897.43) <i>Weekly Benefit: 66 2/3% of covered salary subject to maximum weekly benefit</i>



# 2024 Benefits Enrollment/Change form

Section H: Life Insurance		
ASU Life		
Emp Supplemental	Coverage Level	Information
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<input type="checkbox"/> 1x Annual Base Salary <input type="checkbox"/> 2x Annual Base Salary <input type="checkbox"/> 3x Annual Base Salary <input type="checkbox"/> *4x Annual Base Salary <input type="checkbox"/> *5x Annual Base Salary	<ul style="list-style-type: none"> <li>• Maximum without evidence of good health (EOI): Lesser of 3x or \$500,000.</li> <li>• Maximum with evidence of good health (EOI): \$1,250,000.</li> <li>• Coverage amount rounded up to the nearest \$1,000 increment.</li> <li>• At age 70, coverage is reduced by 60%.</li> <li>• At age 75, coverage is reduced by 75%.</li> </ul> <p>*Requires evidence of good health (EOI) and underwriting approval. Learn more about Securian EOI rules: <a href="https://cfo.asu.edu/asu-life-evidence-insurability">https://cfo.asu.edu/asu-life-evidence-insurability</a>.</p>
Child(ren)	Coverage Level	Information
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<input type="checkbox"/> Child(ren) \$2,500 <input type="checkbox"/> Child(ren) \$7,500 <input type="checkbox"/> Child(ren) \$12,500 <input type="checkbox"/> Child(ren) \$25,000	<ul style="list-style-type: none"> <li>• ASU Life Child insurance cannot exceed 100% of your combined ASU Basic Life and ASU Employee Supplemental Life insurance coverage.</li> <li>• Only one ASU employee can claim an eligible dependent child.</li> </ul>
Spouse	Coverage Level	Information
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<input type="checkbox"/> Spouse \$5,000 <input type="checkbox"/> Spouse \$15,000 <input type="checkbox"/> Spouse \$25,000 <input type="checkbox"/> *Spouse \$50,000	<ul style="list-style-type: none"> <li>• ASU Life Spouse insurance cannot exceed 100% of your combined ASU Basic Life and ASU Employee Supplemental Life insurance coverage.</li> <li>• Married faculty or staff members who both work for ASU may not elect ASU Spouse Life.</li> </ul> <p>*Requires evidence of good health (EOI) and underwriting approval. Learn more about Securian EOI rules: <a href="https://cfo.asu.edu/asu-life-evidence-insurability">https://cfo.asu.edu/asu-life-evidence-insurability</a>.</p>
ADOA Life		
Emp Supplemental	Coverage Level	Information
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	Indicate your coverage amount:  \$ _____	<ul style="list-style-type: none"> <li>• Available in \$5,000 increments.</li> <li>• Maximum: \$500,000 or 3x annual base salary, whichever is less.</li> <li>• Coverage is rounded down to the nearest \$5,000 increment.</li> </ul>
Spouse/Child(ren)	Coverage Level	Information
<input type="checkbox"/> Enroll <input type="checkbox"/> Decline/Cancel <input type="checkbox"/> Change <input type="checkbox"/> No Change	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$12,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$10,000	<ul style="list-style-type: none"> <li>• ADOA Dependent Life insurance cannot exceed 100% of your combined ADOA Basic Life and Supplemental Life Insurance coverage.</li> </ul>

HR Use Only	ASU Life – Emp Supp	$\$ \text{_____ Annual Salary} \times \text{_____ Coverage Level} = \$ \text{_____ Subtotal}$ Subtotal rounded up to nearest \$1,000 = \$ _____ Coverage	EOI Required? <input type="checkbox"/> Yes – Added to SS: _____ <input type="checkbox"/> No
	ASU Life – Child	$\$ \text{_____ Basic} + \$ \text{_____ Supp} = \$ \text{_____ (Total employee coverage)}$	Is employee coverage greater than dependent coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ASU Life – Spouse	$\$ \text{_____ Basic} + \$ \text{_____ Supp} = \$ \text{_____ (Total employee coverage)}$	Is employee coverage greater than dependent coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No EOI Required? <input type="checkbox"/> Yes – Added to <input type="checkbox"/> No SS: _____
	ADOA Life – Sp/Ch	$\$ \text{_____ Basic} + \$ \text{_____ Supp} = \$ \text{_____ (Total employee coverage)}$	Is employee coverage greater than dependent coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No



## Section J: Acknowledgement and Authorization

I certify under penalty of perjury that the information provided in this application for employee benefits, including social security numbers, addresses, spouse and/or dependent child(ren) information, is true and accurate. I further understand that providing false information may subject me to a denial of employee benefits, disciplinary action and prosecution pursuant to A.R.S. §13-2310, 13-2311, 13-2407, 13-2702 and other applicable provisions of the law. I authorize the release of this information to my employer, the Arizona Department of Administration, and insurance carriers. Further:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions (in accordance with IRC Section 125), either prospectively or retroactively, for my elected benefits. Any pre-tax contributions are ineligible as itemized deductions for income tax purposes.
- I understand that I can only change my benefits during open enrollment or by written notification to HR Benefits within 30 calendar days of a qualified life event.
- I understand that while on any unpaid status, I am responsible for paying my benefits premiums. Upon return to paid status, I may have pre-tax or after-tax payroll deductions. If I fail to pay premiums as required, my benefits may be cancelled and I will be responsible for any paid claims.

Print Name:	Signature:	Date:
Employee ID (10 digit):	Email Address:	