City of Phoenix Retiree Open Enrollment Form

Elections effective 1st of the following month in which the form is received by Benefits Office.

ENROLLMENT TYPE	RETIREMENT	PAYMENT OPTION	MEDICAL REIMBURSEMENT
☐ NEW ☐ CHANGE ☐ WAIVE ALL COVERAGE	☐ GENERAL CITY (COPERS) ☐ POLICE ☐ FIRE	☐ PENSION DEDUCTION ☐ DIRECT PAY (INSUFFICIENT PENSION)	☐ PEHP ☐ MERP

1. EMPLOYEE I.D. #	2. LAST NAME	FIRST NAME	MI	3. DATE OF BIRTH

4. PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

5. MAILING ADDRESS	CITY	STATE	ZIP CODE

6. PHONE NUMBER	7. Last 4 SSN	8. EMAIL

9. TYPE OF COVERAGE

☐ Retiree ONLY	☐ Retiree + 1	☐ Spouse ONLY (SSN required)	☐ Family **AND** Retiree	☐ Family **NO** Retiree

10. NON-MEDICARE MEDICAL PLAN SELECTION

UNITED HEALTHCARE (UHC) MEDICAL PLAN	☐ NAVIGATE HMO ☐ CATASTROPHIC PLAN ☐ CHOICE HSA ☐ CHOICE PLUS PPO	☐ **Waive** ☐ **No Change**

11. DENTAL AND VISION PLAN — 12. TYPE OF COVERAGE

DENTAL	☐ HMO ☐ PPO	☐ Single ☐ Retiree + 1 ☐ Family	☐ Waive ☐ PSPRS Dental ☐ No Change	
VISION	☐ Buy Up Vision Plan	☐ Single ☐ Retiree + 1 ☐ Family	☐ Waive ☐ No Change	

13. PLEASE FILL IN THE INFORMATION BELOW WHEN ENROLLING OR ADDING/REMOVING DEPENDENTS. (USE A BLANK FORM TO ADD ADDITIONAL DEPENDENTS. INCLUDE YOUR NAME AND MARK AS PAGE 2)

Add or Del	Mark All That Apply	Last Name	First Name	Check Dependent Type	Gender	DOB MM/DD/YYYY	SSN (SSN required for spouse/QDP only coverage)
	☐ Medical ☐ Dental ☐ Vision			☐ Child ☐ Spouse ☐ QDP ☐ QDP Dep			
	☐ Medical ☐ Dental ☐ Vision			☐ Child ☐ Spouse ☐ QDP ☐ QDP Dep			
	☐ Medical ☐ Dental ☐ Vision			☐ Child ☐ Spouse ☐ QDP ☐ QDP Dep			

- ***Dependent verification documents must be received within 31 days of election date.***
- ***By signing this form, I attest that myself or my enrolled dependents are not Medicare eligible. It is my responsibility to notify the City of Phoenix Benefits Office if and when I or my enrolled dependents become eligible for Medicare and are therefore no longer eligible for this coverage.***
- ***The signature below authorizes the above elections and pension check deductions and VERIFIES MY UNDESTANDING OF THIS INFORMATION.***

14. Signature: **15. Date Signed:**

Received By:	Date:	Entered By:

Submit this form and dependent verification to:
Email: benefits.questions@phoenix.gov
Fax: 602-534-2848

Mail to: City of Phoenix
Benefits Office 7th Floor
251 W. Washington Street
Phoenix, AZ 85003

White: Benefits Office Retiree File

Canary: Retiree/Survivor