



STATE OF ARKANSAS / Arkansas State Retiree
Health Insurance Continuation Information
2006 Plan Year



Provided by:
Employee Benefits Division
Department of Finance & Administration
P. O. Box 15610
Little Rock, AR 72231-5610
Ph. 501-682-9656
Toll Free 877-815-1017
www.ARBenefits.org

Retirement Overview

Upon retirement from your agency, you and your dependents are eligible to continue health coverage through several options which are outlined in detail below. ***The necessary forms must be submitted to Employee Benefits Division within 31 days of your retirement date.***

OPTION A – Health and Life Insurance Continuation under Retirement System

If you are eligible for a retirement benefit from one of the participating retirement systems*, you may continue your current health coverage in the retirement group by having the insurance premium deducted from your retirement check. Complete the form titled “Arkansas State Retiree Payroll Deduction Authorization” (#6200-f-1a) enclosed in this packet. **This is the form that notifies us of your intention to continue your health and/or insurance.** Mail completed form to the Employee Benefits Division at the mailing address listed on the top. If your retirement benefit amount is inadequate to cover the insurance premiums, you will also be asked to set up a bank draft by completing the enclosed form, “Authorization Agreement for Pre-Authorization Payments (#6200-f-7b).”

OPTION B – COBRA Continuation ONLY

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) allows for continuation of health benefits after termination or retirement. If you are not eligible for retirement benefits from one of the participating retirement systems* and would like to retain your current health benefits, you may continue your health insurance for a period of 18 months as a COBRA Continuant. If you have not received a COBRA Election Form in the mail within 14 days of your last date of employment, please contact the Employee Benefits Division at (877) 815-1017 .

OPTION C – COBRA until retirement benefits begin

If you are eligible for retirement (i.e. have enough years of service) but will not immediately receive a retirement benefit, you may choose health insurance coverage under COBRA for a maximum of 18 months (or until you are eligible to receive a retirement check if within the 18 month period). To enroll under COBRA, please read and complete the COBRA Election form that will be mailed to your home. When your retirement benefit begins, you may change to the retirement group by contacting the Employee Benefits Division. *NOTE: It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.*

OPTION D – COBRA when retirement benefits are available

If you are eligible for retirement benefits from one of the participating retirement systems* when you retire, you may continue your health insurance through COBRA if you so choose. COBRA payments are made by bank draft. A bank draft payment is established by completing the “Authorization Agreement for Pre-Authorization Payments (#6200-f-7a)” included in this booklet. At the end of your COBRA benefit eligibility period (18 months) you will need to change to the retiree insurance group in order to continue your health insurance. It is very important to remember that you must remain on COBRA and make timely payments for the **entire** eligibility period to be eligible to begin insurance through the retirement system when COBRA coverage ends. *NOTE: It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.*

OPTION E – Waiver of Enrollment

If you do not wish to continue the Health Insurance coverage at all, please complete the “Decline Coverage” box and then sign and date the “Arkansas State Retiree Payroll Authorization Form (#6200-f-1a).” Once completed, that form should be sent directly to Employee Benefits Division.

**Participating Retirement Systems are: Arkansas Public Employees Retirement System, Arkansas Teacher Retirement System, Judicial Retirement System, Arkansas Highway and Transportation Department Retirement System, and Alternative Retirement System.*

Arkansas State Health Plan Options & Rates

for Retirees not Medicare Primary

Effective January 1, 2006, Self-Insured Health Plan

Health Plan Option	Total Monthly Premium	Less State Contribution	Total Monthly Retiree Cost
Retiree Not Medicare Eligible Only			
ARHealth	\$569.35	(\$357.20)	\$212.15
BCBS PPO	\$570.08	(\$357.20)	\$212.88
NovaSys PPO	\$561.88	(\$357.20)	\$204.68
Health Advantage POS	\$611.10	(\$357.20)	\$253.90
NovaSys POS	\$603.78	(\$357.20)	\$246.58
QualChoice POS	\$628.28	(\$357.20)	\$271.08
Health Advantage HMO	\$595.63	(\$357.20)	\$238.43
NovaSys HMO	\$588.31	(\$357.20)	\$231.11
QualChoice HMO	\$592.55	(\$357.20)	\$235.35
NovaSys High Deductible PPO	\$511.32	(\$357.20)	\$154.12
Retiree Not Medicare Eligible and Spouse Not Medicare			
ARHealth	\$1,138.59	(\$654.81)	\$483.78
BCBS PPO	\$1,140.06	(\$654.81)	\$485.25
NovaSys PPO	\$1,123.66	(\$654.81)	\$468.85
Health Advantage POS	\$1,222.10	(\$654.81)	\$567.29
NovaSys POS	\$1,207.46	(\$654.81)	\$552.65
QualChoice POS	\$1,256.46	(\$654.81)	\$601.65
Health Advantage HMO	\$1,191.16	(\$654.81)	\$536.35
NovaSys HMO	\$1,177.13	(\$654.81)	\$522.32
QualChoice HMO	\$1,185.00	(\$654.81)	\$530.19
NovaSys High Deductible PPO	\$1,022.56	(\$654.81)	\$367.75
Retiree Not Medicare Eligible + Child(ren)			
ARHealth	\$910.94	(\$535.78)	\$375.16
BCBS PPO	\$912.11	(\$535.78)	\$376.33
NovaSys PPO	\$898.99	(\$535.78)	\$363.21
Health Advantage POS	\$977.74	(\$535.78)	\$441.96
NovaSys POS	\$966.03	(\$535.78)	\$430.25
QualChoice POS	\$1,005.23	(\$535.78)	\$469.45
Health Advantage HMO	\$952.99	(\$535.78)	\$417.21
NovaSys HMO	\$941.67	(\$535.78)	\$405.89
QualChoice HMO	\$948.06	(\$535.78)	\$412.28
NovaSys High Deductible PPO	\$818.11	(\$535.78)	\$282.33

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* High Deductible PPO plan no longer requires a mandatory \$20 monthly Health Savings Account Contribution.

Arkansas State Health Plan Options & Rates

for Retirees not Medicare Primary

Effective January 1, 2006: Self-Insured Health Plan

Continued from previous page

Health Plan Option	Total Monthly Premium	Less State Contribution	Total Monthly Retiree Cost
Retiree Not Medicare Eligible and Spouse Not Medicare and Child(ren)			
ARHealth	\$1,709.24	(\$953.08)	\$756.16
BCBS PPO	\$1,711.44	(\$953.08)	\$758.36
NovaSys PPO	\$1,686.84	(\$953.08)	\$733.76
Health Advantage POS	\$1,834.50	(\$953.08)	\$881.42
NovaSys POS	\$1,812.54	(\$953.08)	\$859.46
QualChoice POS	\$1,886.04	(\$953.08)	\$932.96
Health Advantage HMO	\$1,788.09	(\$953.08)	\$835.01
NovaSys HMO	\$1,767.22	(\$953.08)	\$814.14
QualChoice HMO	\$1,778.85	(\$953.08)	\$825.77
NovaSys High Deductible PPO	\$1,535.18	(\$953.08)	\$582.10
Retiree Not Medicare Eligible and Spouse Medicare			
ARHealth	\$854.54	(\$490.29)	\$364.25
BCBS PPO	\$889.11	(\$490.29)	\$398.82
NovaSys PPO	\$872.71	(\$490.29)	\$382.42
Health Advantage POS	\$880.95	(\$490.29)	\$390.66
NovaSys POS	\$866.31	(\$490.29)	\$376.02
QualChoice POS	\$910.02	(\$490.29)	\$419.73
Health Advantage HMO	\$862.12	(\$490.29)	\$371.83
NovaSys HMO	\$847.48	(\$490.29)	\$357.19
QualChoice HMO	\$865.91	(\$490.29)	\$375.62
NovaSys High Deductible PPO	\$812.26	(\$490.29)	\$321.97
Retiree Not Medicare Eligible and Spouse Medicare and Child(ren)			
ARHealth	\$1,186.81	(\$670.27)	\$516.54
BCBS PPO	\$1,234.14	(\$670.27)	\$563.87
NovaSys PPO	\$1,212.82	(\$670.27)	\$542.55
Health Advantage POS	\$1,250.59	(\$670.27)	\$580.32
NovaSys POS	\$1,231.56	(\$670.27)	\$561.29
QualChoice POS	\$1,289.97	(\$670.27)	\$619.70
Health Advantage HMO	\$1,222.48	(\$670.27)	\$552.21
NovaSys HMO	\$1,203.84	(\$670.27)	\$533.57
QualChoice HMO	\$1,224.42	(\$670.27)	\$554.15
NovaSys High Deductible PPO	\$1,122.04	(\$670.27)	\$451.77

* High Deductible PPO plan no longer requires a mandatory \$20 monthly Health Savings Account Contribution.

Arkansas State Health Plan Options & Rates for Retirees Medicare Primary

Effective January 1, 2006: Self-Insured Health Plan

Provided by Employee Benefits Division and administered by Health Advantage

ARHealth Senior	Medical	Prescription Drug	Monthly Premium	Less State Contribution	Total Monthly Retiree Cost
Retiree Medicare Eligible Only	\$127.72	\$168.37	\$296.09	(\$159.77)	\$136.32
Retiree Medicare Eligible and Spouse Not Medicare	513.94	326.77	\$840.71	(457.39)	\$383.32
Retiree Medicare Eligible and Child(ren)	359.45	263.41	\$622.86	(338.35)	\$284.51
Retiree Medicare Eligible and Spouse Not Medicare and Child(ren)	745.68	421.81	\$1,167.49	(637.37)	\$530.12
Retiree Medicare Eligible and Spouse Medicare	255.44	336.74	\$592.18	(292.87)	\$299.31
Retiree Medicare Eligible and Spouse Medicare and Child(ren)	472.18	431.78	\$903.96	(472.85)	\$431.11

Arkansas State Health Plan Options & Rates for COBRA Participants

Effective January 1, 2006: Self-Insured Health Plan

Health Plan Options	Total Monthly Employee Cost (No **HRA Completed)	One **HRA Completed Tobacco User	Non-Tobacco User	Two **HRAs Completed /Two Tobacco Users	One Tobacco and One Non-Tobacco User	Two Non-Tobacco Users
Employee Only						
BCBS PPO	\$469.94	\$459.94	\$449.94	N/A	N/A	N/A
NovaSys PPO	\$461.57	\$451.57	\$441.57	N/A	N/A	N/A
Health Advantage POS	\$348.48	\$338.48	\$328.48	N/A	N/A	N/A
NovaSys POS	\$341.01	\$331.01	\$321.01	N/A	N/A	N/A
QualChoice POS	\$348.03	\$338.03	\$328.03	N/A	N/A	N/A
Health Advantage HMO	\$340.75	\$330.75	\$320.75	N/A	N/A	N/A
NovaSys HMO	\$333.28	\$323.28	\$313.28	N/A	N/A	N/A
QualChoice HMO	\$335.56	\$325.56	\$315.56	N/A	N/A	N/A
*NovaSys HD PPO	\$297.21	\$287.21	\$277.21	N/A	N/A	N/A
Employee & Spouse						
BCBS PPO	\$1,121.41	\$1,111.41	\$1,101.41	\$1,101.41	\$1,091.41	\$1,081.41
NovaSys PPO	\$1,101.33	\$1,091.33	\$1,081.33	\$1,081.33	\$1,071.33	\$1,061.33
Health Advantage POS	\$829.89	\$819.89	\$809.89	\$809.89	\$799.89	\$789.89
NovaSys POS	\$811.98	\$801.98	\$791.98	\$791.98	\$781.98	\$771.98
QualChoice POS	\$828.79	\$818.79	\$808.79	\$808.79	\$798.79	\$788.79
Health Advantage HMO	\$811.33	\$801.33	\$791.33	\$791.33	\$781.33	\$771.33
NovaSys HMO	\$794.05	\$784.05	\$774.05	\$774.05	\$764.05	\$754.05
QualChoice HMO	\$798.90	\$788.90	\$778.90	\$778.90	\$768.90	\$758.90
*NovaSys HD PPO	\$706.84	\$696.84	\$686.84	\$686.84	\$676.84	\$666.84
Employee & Child(ren)						
BCBS PPO	\$700.54	\$690.54	\$680.54	N/A	N/A	N/A
NovaSys PPO	\$687.99	\$677.99	\$667.99	N/A	N/A	N/A
Health Advantage POS	\$518.35	\$508.35	\$498.35	N/A	N/A	N/A
NovaSys POS	\$507.15	\$497.15	\$487.15	N/A	N/A	N/A
QualChoice POS	\$517.65	\$507.65	\$497.65	N/A	N/A	N/A
Health Advantage HMO	\$506.72	\$496.72	\$486.72	N/A	N/A	N/A
NovaSys HMO	\$495.74	\$485.74	\$475.74	N/A	N/A	N/A
QualChoice HMO	\$498.97	\$488.97	\$478.97	N/A	N/A	N/A
*NovaSys HD PPO	\$441.42	\$431.42	\$421.42	N/A	N/A	N/A
Employee & Family						
BCBS PPO	\$1,242.82	\$1,232.82	\$1,222.82	\$1,222.82	\$1,212.82	\$1,202.82
NovaSys PPO	\$1,220.66	\$1,210.66	\$1,200.66	\$1,200.66	\$1,190.66	\$1,180.66
Health Advantage POS	\$920.95	\$910.95	\$900.95	\$900.95	\$890.95	\$880.95
NovaSys POS	\$901.16	\$891.16	\$881.16	\$881.16	\$871.16	\$861.16
QualChoice POS	\$919.74	\$909.74	\$899.74	\$899.74	\$889.74	\$879.74
Health Advantage HMO	\$900.44	\$890.44	\$880.44	\$880.44	\$870.44	\$860.44
NovaSys HMO	\$881.41	\$871.41	\$861.41	\$861.41	\$851.41	\$841.41
QualChoice HMO	\$886.73	\$876.73	\$866.73	\$866.73	\$856.73	\$846.73
*NovaSys HD PPO	\$785.06	\$775.06	\$765.06	\$765.06	\$755.06	\$745.06

* High Deductible PPO plan no longer requires a mandatory \$20 monthly Health Savings Account Contribution.

** Health Risk Assessment

State Retiree Frequently Asked Questions

Who is eligible for retirement health insurance benefits?

- The person was insured or eligible for insurance in the group health insurance plan on the last day actively employed by the school; and
- Meets the requirements to participate under the retirement system's contributory plan or non-contributory plan; and
- Completes an application within **31 days** of retirement. If you do not apply or decline coverage within the 31 days, you cannot enroll at a later date.

What if I take early retirement and do not qualify for retirement benefits?

- You are only eligible to continue the health insurance coverage as a COBRA participant. Once your COBRA has ended (18 months) and you are eligible to participate in one of the retirement plans, you may enroll at that time. If your COBRA ends and you are still not eligible for retirement benefits, you must continue some other coverage (except Medicare) until you become eligible. There cannot be a break in coverage at anytime while you are waiting to become eligible for retirement benefits.

How do I enroll in the retirement health insurance program?

- You must complete an Arkansas State Employee Payroll Deduction Authorization Form and send it to EBD within the 31 day election period. (See enclosed rates for Medicare, Non-Medicare and COBRA.)
- If you are declining coverage at this time, you must complete an Enrollment Form and check the "decline coverage" box for both you and your dependents, if applicable. This form must be sent to EBD within the 31 day election period.

What continued health coverage benefits will my covered dependents have should I die?

Surviving covered dependents of an insured retiree may continue the group health insurance coverage regardless of their option for survivor's benefits. The premiums for this coverage may be deducted from the survivor's benefits if applicable. If no survivor's check is due, the surviving covered dependents will pay premiums directly to EBD on a monthly basis by bank draft only.

Who should be notified of the death of a retiree or dependent?

- EBD should be notified immediately upon the death of a retiree or covered dependent so that we can terminate coverage on that member and notify all health/life carriers. At this time we would initiate the paperwork if there is to be a reduction in premiums.
- Upon notification of the death of a retiree, EBD will send out a Surviving Dependent letter to any covered dependents on the retiree's plan extending the opportunity for them to continue to be covered under the State and Public School Retirement Health Program.

If I am eligible for Medicare, do I have to carry both Part A and Part B as a retiree?

YES. Retirees who are eligible for Medicare must carry Part B (physician). The health insurance carrier will coordinate benefits as if Part B is in force. This means that coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law. Subscribers and Dependents who are eligible for Medicare must have both Part A and B. If a member eligible for Medicare does not have Medicare Part B, the plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for claims incurred. **NOTE:** The general Medicare Open Enrollment period is from January through March each year for a July 1st effective date. Retirees without Medicare Part B should contact the Social Security Administration (at 1-800-772-1213) about obtaining Part B coverage. Medicare Part B premiums are monthly and may increase up to 10% for each 12 month period that you could have had Part B but did not sign up for it (there are some special exceptions).

If I am not eligible for Medicare at the time of retirement, but become eligible at a later date, how do I get the reduced premiums?

You need to send EBD a copy of your Medicare card as soon as you receive it so that we can make the proper adjustments to your account. You will be automatically enrolled in ARHealth (pronounced "Our Health") at 65 if you are Medicare primary.

What if I find my deductions are not correct? Will I get a refund?

- Medicare primary rates will go into effect the first of the month following EBD's receipt of a copy of your Medicare card.
- You need to check your deductions periodically as EBD's policy is to not refund back further than 60 days.

What are the participating retirement systems?

- Arkansas Public Employees Retirement System (APERS)
- Arkansas Teacher Retirement System (ATRS)
- Judicial Retirement System
- Arkansas Highway Retirement System
- Alternative Retirement System

What if my annuity check is not large enough for my insurance premiums?

EBD will set you up as a Cash Retiree and your premiums can only be made by bank draft.

What are the retirement insurance eligibility rules?

- Are you participating in one of the five (5) retirement plans – APERS, ATRS, Highway, Judicial or Alternate?

If yes,

- To be eligible you must have been participating in the group health insurance coverage, or was eligible to participate in the group health insurance coverage on the last day as an active employee. If yes,
- You must apply within 31 days of becoming an active retiree to participate in the group health insurance program. If the retiree does not want to participate in the group health insurance program, they must sign a Declination Form indicating their wish to not participate within 31 days of becoming an active retiree.
- If the retiree declines to participate in the group health insurance program, that decision is final.
- EXCEPTION-LOSS OF ELIGIBILITY. If the retiree is an active retiree and declined coverage from the group health insurance program within thirty-one (31) days of retirement and specified in writing that the reason for the declination of coverage was because he/she (the active retiree) had coverage through another insurance program or group health plan, and later his insurance coverage is terminated because of loss of eligibility, then the retiree and any dependents shall qualify for coverage in the State sponsored program provided the active retiree applies for coverage within thirty-one (31) days of the loss of eligibility. Examples of when loss of eligibility may occur is termination of employment, decrease in the number of hours worked, marriage, divorce or adoption of a child. An example of when loss of eligibility is not applicable is non-payment of premium and termination for cause. A person may not always lose eligibility for insurance coverage through one of the above-cited circumstances, but frequently they do.
- EBD advises retirees to seriously consider participating in the group health insurance offered to them as an active retiree of one of the five retirement programs. If the retiree declines to participate in group health insurance coverage within 31 days of becoming an active retiree, he must qualify for a loss of eligibility as cited above to become active in the group health insurance program.
- If the retiree is currently employed and the employer offers group health insurance coverage, the retiree may enroll in his current employer plan and drop insurance coverage with the Arkansas State and Public School Employees Group Health Insurance. The retiree may then reinstate insurance coverage with the Arkansas State and Public School Employees Group Health Insurance in the future if he/she experiences the loss of eligibility.

When can I make plan changes?

- This year it will be October 1 – 31 to be effective January 1
- If you are moving out of state and have an HMO, you can change to a POS or PPO Plan at the time of relocation. With the POS plan, the benefit is greatly reduced (see page 13).
- The only opportunity for a Retiree to add dependents (other than newly acquired) is if there is a loss of coverage (qualifying or family status change event).

Will I still be covered by life insurance when I retire?

- At your retirement, you can retain all of the life insurance amount you had as an active employee, provided you:
 - o apply within 31 days of retirement
 - o are an annuitant under the Teacher Retirement System or Arkansas Public School Retirement System
- Life insurance premiums will be deducted monthly from your annuity check. If your annuity check is not sufficient to cover your life insurance premiums, you will be billed directly by USABLE Life

Who do I contact to file a life insurance claim if a retiree or dependent dies?

- USABLE Life needs to be contacted directly at 1-800-370-5856.
- If you need to change a beneficiary, please send that information directly to USABLE Life.

How is the ARHealth plan different from the other plans?

- You have open access, which means that you may self-refer to a physician that is in-network and still receive in-network benefits. Out-of-Network benefits are only applied if you receive services from a non-participating provider.
- You will pay a \$20 copayment (PCP) for services provided by one of the following in-network doctors in their office, with no deductible.
 - o General Practitioners
 - o Family Practitioners
 - o Internal Medicine
 - o Pediatricians
- You will pay a \$30 copayment (Specialist) for services provided by an in-network specialist in their office, with no deductible.
- ARHealth members will be able to utilize the Health Advantage network of physicians and facilities.
- If you use an out of state participating Blue Cross provider, you will not be charged the difference between the amount billed by the provider and the Blue Cross-allowed amount. You will be responsible for the deductible, coinsurance or copayment amounts.



Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 <http://www.ARBenefits.org>

**State Employees
 Enrollment Form**



1. Retiree Information: (please print)				<input type="checkbox"/> I decline coverage for myself	
Last Name		First Name		MI	Gender <input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address		City		State	Zip Code
Social Security #:	Date of Birth:	Home #:	Work #:		
†Primary Care Physician:		PCP #	Current patient?		

†Primary Care Physician lines are applicable for HMO and POS enrollees only, not PPO.

2. Dependent Coverage Information:				<input type="checkbox"/> I decline coverage for my dependents		
SP OC SS	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:			
	†Primary Care Physician:		PCP #	Current patient?		
	LAST NAME		FIRST NAME		MI	GENDER
Dep 1*	Social Security #:		Date of Birth:		Full time student?*	
	†Primary Care Physician:		PCP #	Current patient?		
	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?*	
Dep 2*	†Primary Care Physician:		PCP #	Current patient?		
	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?*	
	†Primary Care Physician:		PCP #	Current patient?		
Dep 3*	LAST NAME		FIRST NAME		MI	GENDER
	Social Security #:		Date of Birth:		Full time student?*	
	†Primary Care Physician:		PCP #	Current patient?		

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.

**To be completed for dependents 19 and over only. Please submit proof of student status.

3. I Wish To Enroll In The Following Plan:				
*ARHealth	H M O	P O S	P P O	H D P P O
<input type="checkbox"/> *ARHealth	<input type="checkbox"/> Health Advantage <input type="checkbox"/> NovaSys Health <input type="checkbox"/> QualChoice	<input type="checkbox"/> Health Advantage <input type="checkbox"/> NovaSys Health <input type="checkbox"/> QualChoice	<input type="checkbox"/> Ark. Blue Cross & Blue Shield <input type="checkbox"/> NovaSys Health	<input type="checkbox"/> NovaSys Health
<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee & Spouse		<input type="checkbox"/> Employee & Children
				<input type="checkbox"/> Family

* For Medicare eligible retirees, the ARHealth Plan will not include pharmacy benefits.
 Non Medicare retirees and their non-Medicare dependents will be enrolled in the ARHealth HMO Plan.

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? Yes No

2) If Yes, what type of coverage? Medical Medicare, HIC # _____

If Medicare: Part A Effective Date / / or Part B Eff Date / /

If Medicare: Reason for Coverage: Over age 65 Disabled Kidney Disease

Please make sure EBD and your carrier has a copy of your Medicare card.

If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my retirement earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of the health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**I understand that if I refuse to apply for coverage at retirement,
that I may not be eligible for coverage at a later date.**

Retiree's Signature: _____

Date: _____



Phone: (501) 682-9656

Toll Free: (877) 815-1017

Fax: (501) 683-0983

<http://www.ARBenefits.org>

**Change Form
 Status, Name and Address**



1. Employee Information: (please print)					
Last Name		First Name		MI	<input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address		City	State	Zip Code	
SSN#	Date of Birth:	Home #:	Work #:		
If you would like benefit information sent to you by email, please print your email address:					
Primary Care Physician:		PCP #	Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status):					
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student?*		
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student?*		
LAST NAME		FIRST NAME		MI	GENDER
Social Security #		Date of Birth		<input type="checkbox"/> Add	<input type="checkbox"/> Delete
Primary Care Physician:		PCP #	Full time student?*		

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.

**For dependents 19 and over only. Please submit proof of student status.

3. Change In Coverage (complete this portion if making any of the following changes):	
Change in Status:	Reason for Change:
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> Birth - Date: _____ <input type="checkbox"/> Death - Date: _____ <input type="checkbox"/> Divorce - Date: _____ <input type="checkbox"/> Marriage* - Date: _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name <input type="checkbox"/> Address	

* Please attach Marriage License; Maiden Name if applicable

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ Date: _____



STATE OF ARKANSAS
**Department of Finance
 and Administration**

EBD
 Employee Benefits Division
 Post Office Box 15610
 Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 <http://www.state.ar.us/dfa/ebd>

Authorization Agreement for Pre-Authorization Payments



I (we) hereby authorize the Department of Finance and Administration – Employee Benefits Division to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debits in error to our bank account indicated below at the financial institution named below, hereinafter called Depository, to debit and/or credit the same such account.

Depository Name: _____

Address: _____

Routing Number: _____ Type of Account: Checking
 Savings

Total amount to be deducted monthly: _____

This authorization shall remain in effect unless the Employee Benefits Division has received written notification from me (us) of its termination in such time and in such manner as to afford the Employee Benefits Division and Depository a reasonable opportunity to act on it.

Authorization Signer on Account: _____
 (Please print name clearly)

Insured's Social Security No.: _____

Signature: _____ (Date)
 (Authorized Signer)

ATTACH A VOIDED CHECK HERE

(DEPOSIT SLIP CANNOT BE USED)

Return this authorization to:
 Employee Benefits Division
 P.O. Box 15610
 Little Rock, AR 72231-5610



STATE OF ARKANSAS
**Department of Finance
 and Administration**

EBD
 Employee Benefits Division
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 Little Rock, AR 72231-5610

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Arkansas State Retiree Payroll Deduction Authorization  **R**

(Agency Insurance Rep use only:)

Date Sent: _____

Agency Name: _____ Agency Number: _____

I, _____, hereby authorize you to deduct from my retirement check such amounts as necessary to pay the premiums for my health insurance plan. I further authorize you to pay such amounts to the insurance company providing such personal insurance or to its authorized representative. **This authorization remains in effect until you receive notice from me in writing that it has been changed or revoked.**

The retirement system that I participate in is: **(Check *only* one of the following)**

- Public Employees Retirement System (APERS)
- Teacher Retirement System (ATRS)
- Judicial Retirement System
- Arkansas Highway and Transportation Retirement System
- Alternative Retirement System (Valic, etc) _____ (Indicate which system)

Please indicate last date of employment _____

My current health insurance plan is: **(Check one)**

- ARHealth
- Blue Cross Blue Shield PPO
- Health Advantage HMO
- Health Advantage POS
- QualChoice HMO
- QualChoice POS
- NovaSys HD PPO*
- NovaSys PPO
- NovaSys POS
- NovaSys HMO
- USABLE Life Only

<input type="checkbox"/> Decline Coverage Reason: <input type="checkbox"/> Other Insurance <input type="checkbox"/> Medicare Only <input type="checkbox"/> No Other Coverage <input type="checkbox"/> Tricare
--

Please refer to rate sheet to determine amount(s) to record:

Monthly Amount	Self	Self/Spouse	Self/Children	Family
Health Premium				
Basic Life Volume				
Supplemental Life Volume				
Dependent Life Volume				
Total Premium				

If a member is eligible for Medicare and does not have Part B, the plan will pay as though the member does have Part B and the member will have financial responsibility for claims incurred.

If you or your spouse have Medicare Parts A and B, please provide the following information:

Retiree	Spouse
Medicare HIC # _____	Medicare HIC # _____
Medicare Part A Effective _____	Medicare Part A Effective _____
Medicare Part B Effective _____	Medicare Part B Effective _____

Please sign, date and return within 30 days to the address above, attn: Retirement Section

Signature _____ Date _____ SSN _____

(For Office Use Only) Effective Date: _____ EBD Initials: _____
