RESET PRINT

ARBENEFITS

# STATE & PUBLIC SCHOOL RETIREE ELECTION FORM

## Part 1: Employee Information

| First Name | MI | Last Name | Date of Birth | Gender ☐M ☐F | Social Security Number |
|---|---|---|---|---|---|
| | | | | | |

| Home Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Event | Event Date | Date Annuity Begins | Home/Cell Phone Number | Work Phone Number |
|---|---|---|---|---|
| | | | | |

## Part 2: Action Requested

**Type of Action**

- ☐ Enroll in the Plan
- ☐ Enroll as a Surviving Spouse
- ☐ Add/Drop a Dependent
- ☐ Open Enrollment
- ☐ Cancel Coverage
- ☐ Change Address

**Drug Coverage Option**

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- ☐ ARBenefits
- ☐ Medicare Part D

**Retirement System**

- ☐ APERS (State) 998
- ☐ APERS (School) 059002
- ☐ ATRS (School) 059001
- ☐ ATRS (State) 999
- ☐ HIGHWAY DEPT 091
- ☐ JUDICIAL 021
- ☐ VALIC/TIFF (Bank Draft) 999

**Select a Benefit Option**

☐ Premium ☐ Classic ☐ Basic

**Select a Coverage Level**

☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse ☐ Employee & Family

## Medicare

Our plan requires Medicare Retirees to have both Part A & Part B Medicare

## Part 3: Add/Drop Dependents

To complete the RELATIONSHIP column, use the number that describes your dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardianship - 3, Collateral Dependent - 4

| Add | Drop | Name (First, MI, Last) | Date of Birth | Social Security Number | Male | Female | Relationship |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | | | ☐ | ☐ | |
| ☐ | ☐ | | | | ☐ | ☐ | |
| ☐ | ☐ | | | | ☐ | ☐ | |

## Part 4: Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed if I have a qualifying status change event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 30 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to Î ÐÝÌ ÙÏ Ì health plan/insurer 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 È ÊÓÈÐÔ. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

| Employee Signature | Date | Email Address: |
|---|---|---|
| | | |

**SUBMISSION TO EBD IS FINAL**

ARBenefits • Department of 3ÙÈÕÚÍÖÙÔÈÙÐÖÕÈÕË2ÏÈÙÌË2ÌÙÝÐÊÌÚ • Employee Benefits Division

Post Office Box 15610 • Little Rock, AR 72231-5610 • Fax: 501.682.1200

## Instruction Page

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

NOTE: Retirees or dependents that are Medicare Primary may only enroll in the Premium Plan option. QualChoice is the carrier for the Medicare Primary Premium Plan. A copy of the Medicare card is required for any subscriber and/or spouse.

Note: The ARBenefits Medicare Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the plan will pay as though the member does have Part B, and the member will have full financial responsibility for incurred claims.

Public School Retirees with Medicare do not have pharmacy benefits through this plan. You will be required to obtain a Medicare Part D plan for your pharmacy needs.

Bank Draft Authorization Form, with VOIDED check attached, is needed if your retirement annuity is not large enough for your premium deduction. **WE CANNOT PROCESS WITHOUT A VOIDED CHECK.**

Your premiums are post-tax.

**If you cancel your retirement insurance to leave the plan other than gaining employment with a state or public school agency, the decision is final and you cannot come back to the plan.**

**RECIPROCITY SERVICE**

- A retiree who is fully vested as a state employee AND fully vested as a public school employee (a participating member under both APERS and ATRS and drawing a retirement annuity from each) may choose to enroll in either the ASE or PSE retiree health plan.
- A retiree who is not fully vested under either system, but has enough time between the two systems to be eligible for reciprocity service will be enrolled in the retiree health plan of the system with the most service.

**VESTING**

- State and Public School retirees changed from a ten (10) year vesting to a five (5) years vesting effective 7/01/1997.
- Retirees with service prior to 7/01/1997 are still held to the ten (10) year vesting.
- Non-teaching school retirees that are paid under Arkansas Public Employees Retirement System (APERS) have school rates.
- Most College employed retirees and County retirees are not eligible under the State & Public School Retirement Health Insurance. Reciprocity services from these agencies do not make a retiree eligible for the health insurance.

Proof of dependent eligibility is required. Examples of required documentation are: birth certificates, marriage licenses, court documents and a Certificate of Credible Coverage for loss of coverage. The effective date is the first of the month following the date on the Election Form.

Please mail or fax your completed and signed Health Insurance Election Form to:

ARBenefits
P.O. Box 15610
Little Rock, AR 72231-5610
Fax: 501-682-1200

For assistance, contact ARBenefits at 1-877-815-1017 Monday through Friday, from 8:00 a.m. to 4:30 p.m. CST.

Learn more about plans, costs and providers at www.transform.ar.gov/employee-benefits