AR BENEFITS

State & Public-School Retirement Election Form

Employee Information

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

Mailing Address	City	State	Zip Code

Physical Address

Event	Event Date	Date Annuity Begins	Home/Cell Number

Coverage

Type of Action

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

Choose Retirement System

- ☐ APERS (State) 998
- ☐ APERS (School) 059002
- ☐ APERS Judicial 021
- ☐ Highway Dept. 091
- ☐ ATRS (State) 999
- ☐ ATRS (School) 059001
- ☐ VALIC/TIFF - Alternate Retirement (Bank Draft)

Payment Method

Please complete Bank Draft Authorization Form

- ☐ Annuity
- ☐ Checking
- ☐ Savings

Pre-65 Plan

- ☐ Premium ☐ Basic
- ☐ Classic

Post-65 Plan

- ☐ United HealthCare MAPD
- ☐ Health Advantage Primary

Choose Coverage Level

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

Medicare

OUR PLANS REQUIRE MEDICARE-ELIGIBLE RETIREES TO BE ENROLLED IN BOTH MEDICARE PART A & B.

Add/Drop Dependents

Please check the correct column to ADD a dependent to the plan or DROP a dependent currently covered. Proof of a dependent's eligibility must be submitted with this application for all dependents. To complete the RELATIONSHIP column, use the number that describes the dependent(s). Spouse - 1, Child - 2, Permanent Legal Guardian - 3

ADD	DROP	LEGAL NAME (FIRST, MI, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE	FEMALE	RELATIONSHIP
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying 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 give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the heath plan/insurer, for any administrative purpose, including evaluation of an application or claim. 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

Department of Transformation and Shared Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-682-1200

Instructions

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

Currently United HealthCare is the provider for the Group Medicare Advantage Plan (MAPD) plan and Health Advantage is the provider for the Medicare Primary Premium Plan. Each Medicare eligible member is required to maintain Medicare Part A & B coverage. A copy of the Medicare card is required for any subscriber and/or spouse/dependent.

ARBenefits Medicare Primary Premium Plan for retirees will coordinate as if Medicare Part A & 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 coverage. The member will have full financial responsibility for incurred claims.

Public School Retirees who choose the Medicare Primary Premium Plan will NOT have pharmacy benefits through this plan. You will be required to obtain Medicare Part D for your pharmacy needs.

If you choose the UnitedHealthCare MAPD Plan and enroll in a separate Medicare plan outside of ARBenefits, you will automatically be canceled from ARBenefits coverage. If you have questions about your coverage, call ARBenefits before making your decision.

The Bank Draft Authorization Form, with VOIDED check attached, is required if your retirement annuity is not able to cover the full cost of your premiums. WE CANNOT PROCESS WITHOUT A VOIDED CHECK.

Your premiums are post-tax.

IF YOU CANCEL YOUR RETIREMENT INSURANCE OTHER THAN BY GAINING EMPLOYMENT WITH A STATE AGENCY OR PUBLIC SCHOOL, YOU WILL NOT BE ABLE TO COME BACK TO THE PLAN AND THE DECISION IS FINAL.

Completion of this form does not guarantee coverage on the retirement plan as certain conditions must be met in order to be enrolled on to either ARBenefits Retirement Plans.

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 with the ASE or PSE retirement 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) year vesting period effective 7/1/1997.
- Retirees with service prior to 7/1/1997 are still held to the ten (10) year vesting period.
- Non-teaching school retirees that are paid under Arkansas Public Employees Retirement System (APERS) have school rates.
- Most college and county employed 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: birth certificates, marriage licenses, court documents, and a Certificate of Credible Coverage (COCC) for loss of coverage.

If adding dependent as a permanent legal guardian you must include court documents and they will be subject to annual review.

You can also submit documents online through the ARBenefits Member Portal at www.myarbenefits.org/portal.

For assistance, contact ARBenefits at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:30PM CST or email us at Ask.EBD@arkansas.gov.

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

Coverage is effective the 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-682-1200

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