ARIZONA STATE RETIREMENT SYSTEM (ASRS)
HEALTH INSURANCE PREMIUM BENEFIT AUTHORIZATION

COMPLETE AND SEND TO THE ASRS VIA EMPLOYER SECURE MESSAGING
www.azasrs.gov

Disclosure of member's Social Security number is mandated by Section 6109 of the Internal Revenue Code. The ASRS will use Social Security numbers only to obtain information about an individual's ASRS account and to inform the Internal Revenue Service of distributions and withholdings with respect to the individual's account.

SECTION 1 – Member Information

Social Security Number	Member Name (Last)	(First)	(Middle Initial)

Mailing Address			Daytime Telephone Number
City	**State**	**ZIP**	**Date of Birth (MM/DD/YYYY)**

SECTION 2 – Status Information

Indicate participant status (check ☑ one):

☐ Arizona State Retirement System Retiree ☐ Long Term Disability Plan Participant

Retirement Effective Date: _____ Disability Effective Date: _____

SECTION 3 – Information for Coverage

	Last Name	First Name	Social Security Number	Birth Date (MM/DD/YYYY)	Medicare #
Member					
Dependent					
Dependent					
Dependent					

SECTION 4 – Medical Plan

Carrier Name

Medical Premium Amount
$

Section 5 - Dental Plan

Carrier Name

Dental Premium Amount
$

SECTION 6 – Effective Date Coverage to Begin

Date (MM/DD/YYYY) _____

SECTION 7 – To be Completed by the Employer Health Insurance Premium Benefit Specialist

Employer	Phone Number

☐ By checking this box, I certify that I am the employer representative named below and the information on this form is current and correct. I also understand that typing my name in the Electronic Signature field is the legally binding equivalent to my handwritten signature.

Date

HI Premium Benefit Specialist Electronic Signature	Email Address