

# PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

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Phone: (602) 255-5575 Fax: (602) 296-2371

## NEW HIRE ENROLLMENT FORM

<b>PRINT EMPLOYEE Full Name</b>		<b>SSN</b>		<b>Date of Birth (MM/DD/YYYY)</b>	
<b>Address</b>			<b>City, State and ZIP</b>		
<b>Home Phone</b>	<b>Cell Phone</b>	<b>Work Phone</b>	<b>Email Address</b>	<b>Have you previously been enrolled in this Plan?</b>	
				<input type="checkbox"/> Yes OR <input type="checkbox"/> No	

The Cancer Insurance Program is being extended as a voluntary program pursuant to A.R.S. §§ 38-641-645 and your employer has elected to participate in this Program. Please check your election in the appropriate box below to indicate your selected enrollment effective date, or to decline election of the Program.

1. I understand that I am responsible for paying the full annual premium through my employer as an after-tax deduction. The current annual premium is \$50.00.
2. I understand that my effective date will be my date of membership into an eligible position.
3. I understand that I have 30 days from my date of membership to make this election.
4. I understand that I will remain enrolled in the Program as long as I am in an eligible position and I will be responsible for each additional annual premium through my employer.
5. I understand that I may be eligible to continue this Plan once I retire.
6. I understand that my enrollment will terminate effective with my date of employment termination.
7. I understand that if I transfer to another agency that is also enrolled in the Program, I will need to notify my new employer and I will need to complete a new enrollment form within 30 days of the transfer.
8. I understand that the information regarding this benefit can be located at [www.psprs.com](http://www.psprs.com).

I wish to enroll in the Cancer Insurance Program and agree to the terms listed above. I understand my effective date will be my membership date, \_\_\_\_\_.

I wish to decline enrollment into the Cancer Insurance Program.

<b>REQUIRED Employee Signature</b> (electronic signature cannot be accepted)	<b>Date (MM/DD/YYYY)</b>

<b>TO BE COMPLETED BY EMPLOYER</b>	
<b>Print EMPLOYER Name</b>	<b>Employee Date of Hire (MM/DD/YYYY)</b>
Is this employee a transfer? <input type="checkbox"/> Yes OR <input type="checkbox"/> No	If the employee is a transfer, verify premiums were paid through the previous employer and if no premiums are due for the current fiscal year.

<b>PRINT Name of Agency Representative</b>	<b>Date (MM/DD/YYYY)</b>

<b>REQUIRED Signature of Agency Representative</b> (electronic signature cannot be accepted)	<b>Date (MM/DD/YYYY)</b>