REQUEST FOR PUBLIC SAFETY SUBSIDY FORM

(City of Phoenix Public Safety/EORP Retirees Only)

251 W. Washington, 7th Floor Phoenix, Arizona 85003
www.phoenix.gov/benefits
Phone (602) 262-4777
Fax (602) 534-2848
Scan/Email to public.subsidy@phoenix.gov

SECTION 1 – PRINT Retiree or Survivor Information

SSN	Last Name	First Name, Middle Initial
Mailing Address - check box if new ☐	Phone	Email
Select ONE	Date of Birth	NOTES:
☐ New Retiree ☐ New Survivor ☐ Renewal-Annual Update ☐ Newly Medicare ☐ Change of Address	 *Month/Day/Year* Effective date of new coverage	If you know your City of Phoenix employee ID number, please list it here:
Type of Coverage	Monthly Subsidy Amounts *(max)*	
☐ Single Coverage ☐ Family Coverage (If family coverage, must list Section 5 dependent information)	$150-single, not Medicare eligible $260-family, no one Medicare eligible $100-single, Medicare $170-family, both Medicare $215-combo, at least one Medicare	

SECTION 2 – MEDICAL

☐ New Coverage	Retiree/Survivor Monthly Premium:		Carrier Name:
☐ Changed Coverage	Dependent Cost:		
☐ No change in coverage	Total **Monthly** Premium:	$	

SECTION 3 – DENTAL

☐ New Coverage	Retiree/Survivor Monthly Premium:		Check one: ☐ City of Phoenix Retiree ☐ PSPRS/State of Arizona Retiree ☐ Private
☐ Changed Coverage	Dependent Cost:		
☐ No change in coverage	Total **Monthly** Premium:	$	

SECTION 4 – VISION

☐ New Coverage	Retiree/Survivor Monthly Premium:		Check one: ☐ City of Phoenix Retiree ☐ PSPRS/State of Arizona Retiree ☐ Private
☐ Changed Coverage	Dependent Cost:		
☐ No change in coverage	Total **Monthly** Premium:	$	

SECTION 5 - DEPENDENT INFOMATION

Last Name, First Name	Relationship	SSN	DOB (mm/dd/yyyy)	Sex

Signature: