



City of Phoenix Retiree Enrollment Form

Effective Date: _____

ENROLLMENT TYPE

NEW
CHANGE
WAIVE ALL COVERAGE

RETIREMENT

GENERAL CITY
(COPERS)
POLICE
FIRE

PAYMENT OPTION

PENSION
DEDUCTION

MEDICAL REIMBURSEMENT

PEHP
MERP

1. EMPLOYEE I.D. #	2. LAST NAME	FIRST NAME	MI	3. DATE OF BIRTH
4. PHYSICAL ADDRESS				
CITY STATE ZIP CODE				
5. MAILING ADDRESS				
CITY STATE ZIP CODE				
6. PHONE NUMBER	7. Last 4 SSN	8. EMAIL		

11. DENTAL AND VISION PLAN

12. TYPE OF COVERAGE

DENTAL

☐ HMO

☐ PPO

☐ Single ☐ Retiree + 1 ☐ Family

☐ Waive No Change

VISION

☐ Buy Up Vision Plan

☐ Single ☐ Retiree + 1 ☐ Family

☐ Waive No Change

13. PLEASE FILL IN THE INFORMATION BELOW WHEN ENROLLING OR ADDING/REMOVING DEPENDENTS. (USE A BLANK FORM TO ADD ADDITIONAL DEPENDENTS. INCLUDE YOUR NAME AND MARK AS PAGE 2)

Add or Del	Mark All That Apply	Last Name	First Name	Check Dependent Type	Gender	DOB MM/DD/YYYY	SSN (SSN required for spouse/QDP only coverage)
	Dental Vision			Child Spouse QDP QDP Dep			
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- Dependent verification documents must be received within 31 days of election date.
- The signature below authorizes the above elections and pension check deductions and VERIFIES MY UNDERSTANDING OF THIS INFORMATION.

14. Signature:

15. Date Signed:

Received By:	Date:	Entered By:
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Submit this form and dependent verification to:
Email: benefits.questions@phoenix.gov
Fax: 602-534-2848

Mail to: City of Phoenix
Benefits Office 7th Floor
251 W. Washington Street
Phoenix, AZ 85003