



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	<input type="checkbox"/> HMO <input type="checkbox"/> PPO	<input type="checkbox"/> Single <input type="checkbox"/> Retiree + 1 <input type="checkbox"/> Family	<input type="checkbox"/> Waive	No Change
VISION	<input type="checkbox"/> Buy Up Vision Plan	<input type="checkbox"/> Single <input type="checkbox"/> Retiree + 1 <input type="checkbox"/> Family	<input type="checkbox"/> 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 ASPAGE 2)

Add or Del	Mark All That Apply	Last Name	First Name	Check Dependent Type	Gender	DOB MM/DD/YYYY	SSN
	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