



**2009 MIAMI-DADE BENEFITS ELECTION FORM FOR GROUP HEALTH PLANS**

**FORM FOR OVERAGE CHILDREN AGE 25+ to 30**

(\*Please refer to INSTRUCTIONS on reverse side)

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree, F.S. Section 817.234 (1) (b) (2002) FL

SOCIAL SECURITY NUMBER

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LAST NAME  FIRST NAME  MI

ADDRESS  CITY  STATE  ZIP CODE

HOME PHONE  WORK PHONE  DATE OF BIRTH  DATE OF HIRE

SEX:  Male  Female  
 STATUS: MARK ONE:  Open enrollment  Change in status  New hire  
 EFFECTIVE DATE  EMPLOYEE STATUS  DEPARTMENT   
 BARGAINING UNIT

**GROUP HEALTH PLANS (RATES INDICATED ARE BIWEEKLY)**

6. MEDICAL Your current enrollment is for:  
 You must complete to select your medical plan for 2009.

	AVMED POS	AVMED HMO HIGH	AVMED HMO LOW
Employee only	<input type="checkbox"/> 12.35	<input type="checkbox"/> .00	<input type="checkbox"/> .00
Employee + Child(ren)	<input type="checkbox"/> 220.03	<input type="checkbox"/> 138.67	<input type="checkbox"/> 130.78
Employee + Spouse	<input type="checkbox"/> 265.19	<input type="checkbox"/> 160.06	<input type="checkbox"/> 150.97
Employee + Family	<input type="checkbox"/> 458.42	<input type="checkbox"/> 219.22	<input type="checkbox"/> 206.85

	JMH HMO HIGH	JMH HMO LOW
Employee only	<input type="checkbox"/> .00	<input type="checkbox"/> .00
Employee + Child(ren)	<input type="checkbox"/> 138.67	<input type="checkbox"/> 130.78
Employee + Spouse	<input type="checkbox"/> 160.06	<input type="checkbox"/> 150.97
Employee + Family	<input type="checkbox"/> 219.22	<input type="checkbox"/> 206.85

**FORM DUE 11/03/08**

Coverage will not be continued automatically for currently enrolled children age 25. To continue their coverage, you must complete this form.

COVERAGE FOR CHILDREN 25+ to 30 IS LIMITED TO MEDICAL ONLY.

The eligibility requirements for overage children are:

- 1) Must not be married,
- 2) Cannot have any dependents (i.e. children, domestic partner),
- 3) Are not provided or otherwise have available other major medical health insurance, and
- 4) Either live in Florida or are a student.

Attach supporting eligibility documents to this election form.

**9. DEPENDENT INFORMATION - List all overage (25+ - 30) children to be covered for 2009.**

New participants must select a primary care physician if enrolling for a low option HMO plan.

Last	First	Social Security #	D.O.B MM/DD/YYYY	Sex	PCF Name	PCF #	Dental Provider #	Medical
employee				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>
child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>
child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>
child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>
child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>
child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>
child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>
child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/>

Are any of the dependents listed above new for 2009?  YES  NO

Are you or any members of your family covered by any other health insurance?  YES  NO

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND AGREED TO THE TERMS AND CONDITIONS ON THE REVERSE SIDE OF THIS APPLICATION.

10. SIGNATURE

DATE



S0000004

# GROUP MEDICAL, DENTAL PLANS AND OPTIX VISION PLAN

6. Review your current medical coverage. Complete this section to select your medical coverage for 2009. Please mark the appropriate box indicating which coverage you are electing, even if you are staying in the same medical plan, if you wish to add or delete dependents from your plan, this is a change.
7. Review your current dental coverage. Complete this section only if you wish to make a change for 2009. If you wish to make a change, please mark the appropriate box indicating which coverage you are electing. Even if you are staying in the same dental plan, if you wish to add or delete dependents from your plan, this is a change.
8. Review your current OPTIX vision coverage. If you wish to make a change (ex., add or delete dependents, enroll for coverage or cancel coverage), please complete this section. This plan is available to all eligible employees regardless of Union affiliation.
9. If you made any changes to your medical, dental or vision plan for 2009:
  - List yourself and all dependents you wish to cover in 2009 for medical, dental or vision.
  - Provide social security number for each dependent.
  - Provide sex and date of birth.
  - All low option HMO plan enrollees must select a primary care physician.
  - New enrollees in a prepaid dental plan must select a dental provider.
  - Fill in bubbles under medical/dental/vision columns to indicate those enrollees who will be covered for medical, dental and/or vision coverage.
  - Contact your departmental personnel representative if any additional space is required for listing dependents.
  - Indicate if any of the dependents listed are new.
  - Indicate whether you or other covered family members have other health insurance.
10. Carefully read the section below marked "Important Terms and Conditions," then sign and date your forms. Make a copy of this form for your records.

## IMPORTANT TERMS AND CONDITIONS

- I authorize my employer to deduct from my pay the applicable premium contribution to maintain the benefit coverage's I selected, including any return check service fees in accordance to Florida Statute 832.07, if my personal check or money order submitted while on leave without pay status, is returned by the bank for insufficient funds.
- I certify that the information supplied in this application is true to the best of my knowledge.
- I understand that once this form is submitted, I cannot request a change of medical insurance carrier, dental plan carrier or vision plan carrier until the enrollment for 2010. A change of coverage type may be requested to add a newly acquired dependent within 45 days of the event (60 days for newborns), or to add or delete existing dependents subject to the requirements of Flexible Benefits and HIPAA. Please refer to the 2009 Benefits Handbook for specifics.
- I agree to complete and submit to any provider of health services such consents, release, and other assignments as are reasonably necessary for any provider in accordance with its rights under the health benefit plans or insurance policies. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review.
- I authorize any provider of health services to release, upon written request, any information concerning the health, condition, or treatment of any covered person whenever such information is considered necessary for the proper disposition of a claim submitted for payment or in fulfillment of obligations
- I understand that eligible unmarried, dependent children may be covered until the end of the calendar year in which the child reaches age 19. Coverage may be extended to the end of the calendar year in which the child reaches age 25 provided that the child is primarily dependent upon the insured for support and living in the household of the insured, or the child is a full-time or part-time student. Unmarried dependent children from age 25 to age 30 (end of calendar year) may be covered if: 1.) the child is unmarried and does not have any dependents of their own, 2.) the child is a resident of the state of Florida, or a part-time or full time student. Premium for this group will be deducted post tax and subject to imputed income tax. See Benefits Handbook for more specifics. Documentation will be required. Failure to provide the documentation will make the dependent ineligible. Contact the plan regarding extension of benefits for disabled dependents.
- I understand if a new dependent has a different last name than mine, legal documentation evidencing dependent status must be attached to this completed form and submitted to Benefits Administration Unit or your DPR.
- Premiums attributable to a domestic partner or their children will be deducted post tax and subject to imputed income tax.

## NEW HIRES

- I understand I must submit legal documents (example: marriage certificate, birth certificate, certificate of domestic partnership, etc.) to the Benefits Administration Unit of Risk Management, GSA evidencing the relationship of all dependents listed with the same last name as mine, when I submit my enrollment form. My dependent(s) will not be enrolled without the legal documentation.
- I agree for myself and covered members of my family to be bound by the benefits, deductibles, co-payments, exclusions, limitations, and other terms of the Contract, Agreement and Plan Documents.