2012 RETIREE GROUP HEALTH PLAN ELECTION FORM

*For **Retirees Over Age 65 and/or Medicare** Eligible*

Name: _____ **Emp. ID:** _____ **Date of Retirement:** _____
Address: _____ **City:** _____ **State:** ____ **Zip:** _____
Date of Birth: _____ **Phone:** _____ **E-Mail Address:** _____

MEDICAL COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates	AvMed Low Opt. Plan	AvMed High Opt Plan	AvMed High Opt No RX Plan
Retiree over 65 Only	☐ $ 403.74	☐ $ 452.10	☐ $ 196.51
Retiree over 65 & Spouse/DP Over 65*		☐ $ 914.55	☐ $ 397.53
Retiree over 65 & Spouse/DP Under 65* on AvMed POS Plan		☐ $ 1,384.62	☐ $ 1,129.03
Retiree over 65 & Spouse/DP Under 65* on AvMed High Opt. HMO		☐ $ 863.27	☐ $ 597.32
Retiree over 65 & Child(ren)* on AvMed POS Plan		☐ $ 1,326.15	
Retiree over 65 & Child(ren)* on AvMed High Opt. HMO		☐ $ 888.34	
Retiree over 65 & Spouse/DP Under 65, Child(ren) on AvMed POS Plan		☐ $ 1,772.05	☐ $ 1,516.46
Retiree over 65 & Spouse/DP Under 65, Child(ren) on AvMed High Opt. HMO		☐ $ 1,181.92	☐ $ 926.33

Dependent Coverage Only For Retiree over 65 w/ Non-County Medicare Plan	AvMed POS	AvMed HMO High Opt	AvMed HMO Low Opt
Spouse/DP* Under 65	☐ $ 932.52	☐ $ 400.81	☐ $ 377.54
Child(ren)*	☐ $ 874.05	☐ $ 436.24	
Spouse/DP Under 65 and Child(ren) *	☐ $1,866.27	☐ $ 729.82	

DENTAL COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates	Delta Dental Plan Standard	Delta Dental Plan Enriched	MetLife DHMO (Safeguard)* Standard	MetLife DHMO (Safeguard)* Enriched	Humana - Oral Health Services* Standard	Humana - Oral Health Services* Enriched
Retiree Only	☐ $ 31.22	☐ $ 40.87	☐ $ 8.70	☐ $ 12.67	☐ $ 7.99	☐ $ 14.80
Retiree & one dependent	☐ $ 61.76	☐ $ 80.81	☐ $ 14.38	☐ $ 21.00	☐ $ 13.23	☐ $ 24.57
Retiree & dependents	☐ $ 99.55	☐ $130.30	☐ $ 22.01	☐ $ 33.38	☐ $ 20.23	☐ $ 39.03

** Metlife DHMO and Humana-OHS plans are not available outside Miami-Dade, Broward & Palm Beach Counties*

If medical and/or dental coverage for dependent(s) is selected, please provide their information below.

Name	Relationship**	SSN	DOB	Sex M/F	Indicate Coverage Selected
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental

****SP**- Spouse, **CH**-Child, **DP**-Domestic Partner, **DPCH**- Child of Domestic Partner

LIFE INSURANCE COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Life Insurance Benefit	Monthly Rates Age 65-69	Age 70-74	Age 75+
$15,000	☐ $ 8.55	☐ $14.10	☐ $19.50
$20,000	☐ $11.40	☐ $18.80	☐ $26.00

Please sign, date, and mail or fax this form to:
Miami-Dade County
Benefits Administration Unit
111 NW 1st Street, Suite 2340
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368

GREEN PLEDGE I DO _____ I DO NOT _____ authorize the BAU, when practical, to communicate with me via the email address I provided in lieu of utilizing the mail. I will provide BAU with any changes to my email address or preferred choice for communication. I am responsible for monitoring emails and responding to time-sensitive information.

_____ I am aware that it is my responsibility to read and understand the contents of the Retiree Insurance Benefits Handbook available at www.miamidade.gov/benefits/retirement.asp

FOR OFFICE USE ONLY - EG - EI - INV
FRS IPDAF: ☐ **Needed** ☐ **Not Needed**
Conv. Letter: Yes ☐ **No** ☐
Basic Life Conv. Amount $ _____
Optional Life Conv. Amount $ _____

_____ **Signature** _____ **Date**