



# 2013 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	<input type="checkbox"/> \$ 415.99	<input type="checkbox"/> \$ 465.81	<input type="checkbox"/> \$ 202.47
Retiree over 65 & Spouse/Domestic Partner Over 65	<input type="checkbox"/> \$ 837.71	<input type="checkbox"/> \$ 938.04	<input type="checkbox"/> \$ 407.74
Retiree over 65 & Spouse/ Domestic Partner Under 65 on AvMed POS Plan		<input type="checkbox"/> \$1,495.81	<input type="checkbox"/> \$1,232.47
Retiree over 65 & Spouse/ Domestic Partner Under 65 on AvMed High Opt. HMO		<input type="checkbox"/> \$ 886.16	<input type="checkbox"/> \$ 622.82
Retiree over 65 & Child(ren) on AvMed POS Plan		<input type="checkbox"/> \$1,367.98	<input type="checkbox"/> \$1,104.64
Retiree over 65 & Child(ren) on AvMed High Opt. HMO		<input type="checkbox"/> \$ 920.49	<input type="checkbox"/> \$ 657.15
Retiree over 65 & Spouse/ Domestic Partner Under 65, Child(ren) on AvMed POS Plan		<input type="checkbox"/> \$1,845.61	
Retiree over 65 & Spouse/ Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO		<input type="checkbox"/> \$1,226.11	<input type="checkbox"/> \$ 962.77

  

Dependent Coverage Only For Retirees over 65 w/ Non-County Medicare Plan	AvMed POS	AvMed HMO High Opt	AvMed HMO Low Opt
Spouse/ Domestic Partner Under 65	<input type="checkbox"/> \$1,030.00	<input type="checkbox"/> \$ 420.35	<input type="checkbox"/> \$ 395.90
Child(ren)	<input type="checkbox"/> \$ 902.17	<input type="checkbox"/> \$ 454.68	<input type="checkbox"/> \$ 428.47
Spouse/ Domestic Partner Under 65 and Child(ren)	<input type="checkbox"/> \$1,932.17	<input type="checkbox"/> \$ 875.03	<input type="checkbox"/> \$ 824.37

## DENTAL COVERAGE SELECT DECLINE

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

Monthly Rates	Delta Dental Plan		MetLife* DHMO (Safeguard)		Humana* - Oral Health Services	
	Standard	Enriched	Standard	Enriched	Standard	Enriched
Retiree Only	<input type="checkbox"/> \$ 31.22	<input type="checkbox"/> \$ 40.87	<input type="checkbox"/> \$ 8.70	<input type="checkbox"/> \$ 12.67	<input type="checkbox"/> \$ 8.23	<input type="checkbox"/> \$ 15.26
Retiree & one dependent	<input type="checkbox"/> \$ 61.76	<input type="checkbox"/> \$ 80.81	<input type="checkbox"/> \$ 14.38	<input type="checkbox"/> \$ 21.00	<input type="checkbox"/> \$ 13.63	<input type="checkbox"/> \$ 25.32
Retiree & dependents	<input type="checkbox"/> \$ 99.55	<input type="checkbox"/> \$130.30	<input type="checkbox"/> \$ 22.01	<input type="checkbox"/> \$ 33.38	<input type="checkbox"/> \$ 20.84	<input type="checkbox"/> \$ 40.22

\* 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
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental
					<input type="checkbox"/> Medical <input type="checkbox"/> 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	<input type="checkbox"/> \$ 8.55	<input type="checkbox"/> \$14.10	<input type="checkbox"/> \$19.50
\$20,000	<input type="checkbox"/> \$11.40	<input type="checkbox"/> \$18.80	<input type="checkbox"/> \$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](http://www.miamidade.gov/benefits/retirement.asp)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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