2014 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	☐ $ 487.48	☐ $ 545.87	☐ $ 237.27
Retiree over 65 & Spouse/Domestic Partner Over 65	☐ $ 960.20	☐ $1,075.19	☐ $ 467.36
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed POS Plan		☐ $1,598.61	☐ $1,290.01
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed High Opt. HMO		☐ $ 977.97	☐ $ 669.37
Retiree over 65 & Child(ren) on AvMed High Opt. HMO		☐ $1,011.66	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan		☐ $1,961.65	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO		☐ $1,324.52	☐ $1,015.92

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	☐ $1,052.74	☐ $ 432.10	☐ $ 406.96
Child(ren)		☐ $ 465.79	
Spouse/Domestic Partner Under 65 and Child(ren)	☐ $1,971.83	☐ $ 897.89	☐ $ 845.87

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	☐ $ 8.00	☐ $ 14.82
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	☐ $ 20.22	☐ $ 39.02

** 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

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

Signature _____ **Date** _____

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FRS IPDAF: _____ **Needed** _____ **Not Needed**

Basic Life Conv. Amount $ _____

Conv. Letter: Yes _____ **No** _____

Optional Life Conv. Amount $ _____

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