2016 NEW RETIREE INSURANCE BENEFITS ELECTION FORM

For Retirees Under Age 65

Name: _____ Emp. ID: _____ Date of Retirement: _____

Address: _____ City, State, & Zip Code: _____

Date of Birth: _____ Phone: _____ E-Mail Address: _____

MEDICAL COVERAGE ☐ SELECT ☐ DECLINE

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

Monthly Rates	AvMed POS	AvMed High Opt HMO	AvMed MDC Select Network HMO*	AvMed MDC Jackson First HMO*
Retiree or Spouse/Domestic Partner Under 65	☐ $1,165.23	☐ $ 490.30	☐ $ 441.65	☐ $ 409.35
Retiree Under 65 & Spouse/Domestic Partner Under 65	☐ $2,254.09	☐ $1,097.61	☐ $ 995.56	☐ $ 927.76
Retiree Under 65& Child(ren)	☐ $2,168.07	☐ $1,010.99	☐ $ 916.44	☐ $ 853.64
Retiree Under 65 & Spouse/Domestic Partner Under 65, plus Child(ren)	☐ $2,759.20	☐ $1,359.67	☐ $1,235.19	☐ $1,152.51

**AvMed Plans not available outside Miami-Dade, Broward & Palm Beach Counties*

Retiree Under 65 & Spouse/DP Medicare Eligible

Monthly Rates (Must be enrolled in Medicare Parts A and B to be eligible for any of the AvMed over 65 plans)	AvMed POS	AvMed High Opt HMO	AvMed MDC Select Network HMO*	AvMed MDC Jackson First HMO*
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible - High Opt Plan	☐ $ 1,810.78	☐ $ 1,135.85	☐ $ 1,087.20	☐ $ 1,054.90
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible - No RX Plan		☐ $ 770.89	☐ $ 722.24	☐ $ 689.94

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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	☐ $ 31.22	☐ $ 40.87	☐ $ 11.51	☐ $ 16.76	☐ $ 8.00	☐ $ 14.82
Retiree & one dependent	☐ $ 61.76	☐ $ 80.80	☐ $ 19.02	☐ $ 27.77	☐ $ 13.24	☐ $ 24.58
Retiree & dependents	☐ $ 99.55	☐ $130.30	☐ $ 29.11	☐ $ 44.15	☐ $ 20.22	☐ $ 39.02

** Metlife DHMO and 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 the 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

The value of the Miami-Dade County Retiree Group Life Insurance Policy is one-time your base annual salary at the time of retirement. The 2016 rate is 19.5 cents per thousand dollars per month.

_____ Initials

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

FOR OFFICE USE ONLY - EG - EI - INV

FRS IPDAF: _____ Needed _____Not Needed Conv. Letter: Yes _____ No _____

Basic Life Conv. Amount $ _____ 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 2324
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368