



2017 NEW RETIREE INSURANCE BENEFITS ELECTION FORM

For Retirees Over Age 65 and/or Medicare Eligible

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

(Must be enrolled in Medicare Parts A and B to be eligible for any of the AvMed over 65 plans)

	AvMed Low Opt. Plan	AvMed High Opt Plan	AvMed High Opt No RX Plan
Retiree over 65 Only	<input type="checkbox"/> \$ 602.10	<input type="checkbox"/> \$ 674.23	<input type="checkbox"/> \$ 293.06
Retiree over 65 & Spouse/Domestic Partner Over 65	<input type="checkbox"/> \$1,156.58	<input type="checkbox"/> \$1,295.09	<input type="checkbox"/> \$ 562.95
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed POS Plan		<input type="checkbox"/> \$1,885.29	<input type="checkbox"/> \$1,504.12
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed High Opt. HMO	<input type="checkbox"/> \$1,116.10	<input type="checkbox"/> \$1,188.23	<input type="checkbox"/> \$ 807.06
Retiree over 65 & Child(ren) on AvMed High Opt. HMO	<input type="checkbox"/> \$1,145.18	<input type="checkbox"/> \$1,217.31	<input type="checkbox"/> \$ 836.14
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan		<input type="checkbox"/> \$2,340.80	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO		<input type="checkbox"/> \$1,580.59	<input type="checkbox"/> \$1,199.42
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed Select Network HMO		<input type="checkbox"/> \$1,502.15	

Dependent Coverage Only

For Retiree over 65 w/ Non-County Medicare Plan

	AvMed POS	AvMed HMO High Opt	AvMed MDC Select Network HMO*	AvMed MDC Jackson First HMO*
Spouse/Domestic Partner Under 65	<input type="checkbox"/> \$ 1,211.06	<input type="checkbox"/> \$ 514.00	<input type="checkbox"/> \$ 463.71	<input type="checkbox"/> \$ 430.30
Child(ren)		<input type="checkbox"/> \$ 543.08	<input type="checkbox"/> \$ 495.59	
Spouse/Domestic Partner Under 65 and Child(ren)	<input type="checkbox"/> \$ 2,248.04	<input type="checkbox"/> \$1,057.08	<input type="checkbox"/> \$ 959.30	<input type="checkbox"/> \$ 894.36

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

DENTAL COVERAGE

☐ SELECT

☐ DECLINE

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

Monthly Rates

	Delta Dental DPPO		Delta Dental DHMO	
	Standard	Enriched	Standard	Enriched
Retiree Only	<input type="checkbox"/> \$ 29.03	<input type="checkbox"/> \$ 40.87	<input type="checkbox"/> \$ 10.08	<input type="checkbox"/> \$ 11.29
Retiree & one dependent	<input type="checkbox"/> \$ 57.44	<input type="checkbox"/> \$ 80.80	<input type="checkbox"/> \$ 16.65	<input type="checkbox"/> \$ 18.72
Retiree & dependents	<input type="checkbox"/> \$ 92.58	<input type="checkbox"/> \$ 130.30	<input type="checkbox"/> \$ 25.48	<input type="checkbox"/> \$ 29.77

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"/> \$ 10.26	<input type="checkbox"/> \$ 16.92	<input type="checkbox"/> \$ 23.40
\$20,000	<input type="checkbox"/> \$ 13.68	<input type="checkbox"/> \$ 22.56	<input type="checkbox"/> \$ 31.20

 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

Status: Ret. Kind:

Longevity: FRS _____ County _____

Ret. Type:

Other Remarks: _____

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