RETIREE GROUP INSURANCE
ANNUAL ENROLLMENT CHANGE FORM FOR 2015

RETIREE:
Name: _____ **Retiree ID:** _____

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

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

PLEASE READ BEFORE YOU CONTINUE

If you **DO NOT** wish to make changes to your current benefits, **NO ACTION** is required on your part (**DO NOT TURN IN THIS FORM**).
If you WISH to make changes to your current benefits, you MUST return this form to our office no later than December 1, 2014.
Existing dependents may NOT be added to your coverage during this enrollment period.

DENTAL COVERAGE

Please select (√) one of the following options:

Monthly Rates for:	Delta Dental Plan		MetLife DHMO (Safeguard)*		Humana - Oral Health Services*	
	Standard	Enriched	Standard	Enriched	Standard	Enriched
RETIREE ONLY	☐ $ 31.22	☐ $ 40.87	☐ $ 10.01	☐ $ 14.57	☐ $ 8.00	☐ $ 14.82
RETIREE & ONE DEPENDENT	☐ $ 61.76	☐ $ 80.80	☐ $ 16.54	☐ $ 24.15	☐ $ 13.24	☐ $ 24.58
RETIREE & DEPENDENTS	☐ $ 99.55	☐ $130.30	☐ $ 25.31	☐ $ 38.39	☐ $ 20.22	☐ $ 39.02

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

CANCELLATIONS

Select the insurance coverage(s) you want to **CANCEL** effective January 1, 2015. Please note that all cancellations are **IRREVOCABLE**.

Name	Relationship*	Cancel
	SELF	☐ Dental ☐ Life
		☐ Dental
		☐ Dental
		☐ Dental

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

Please sign, date, and mail or fax this form
by December 1, 2014 to:
Miami-Dade County
Human Resources - Benefits Administration
111 NW 1st Street, Suite 2324
Miami, FL 33128
Fax: 305-375-1633 or 305-375-1368

Signature **Date**