RETIREE GROUP INSURANCE
ANNUAL ENROLLMENT CHANGE FORM FOR 2015

*For Retirees **Over Age 65 and/or Medicare** Eligible*

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 submit this form to our office no later than December 1, 2014.
Existing dependents may NOT be added to your coverage during this enrollment period.
If the coverage option desired is not listed, contact your BAU specialist.

MEDICAL COVERAGE

If changing plan, 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	☐ $ 501.72	☐ $ 561.82	☐ $ 244.20
Retiree over 65 & Spouse/Domestic Partner Over 65		☐ $ 1102.52	☐ $ 479.24
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed POS Plan		☐ $ 1648.10	☐ $ 1330.48
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed High Opt. HMO		☐ $ 1011.27	☐ $ 693.65
Retiree over 65 & Child(ren) on AvMed High Opt. HMO		☐ $ 1043.98	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan		☐ $ 2030.72	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO		☐ $ 1367.52	☐ $ 1049.90

Dependent Coverage Only For Retiree over 65 w/ Non-County Medicare Plan	**AvMed POS**	**AvMed HMO High Opt**	**AvMed Select**
Spouse/Domestic Partner Under 65	☐ $ 1086.28	☐ $ 449.45	☐ $ 403.67
Child(ren)		☐ $ 482.16	☐ $ 438.95
Spouse/Domestic Partner Under 65 and Child(ren)	☐ $ 2030.33	☐ $ 931.61	☐ $ 842.62

Additional rates/options available upon request

DENTAL COVERAGE

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	☐ $ 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 Humana-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 all cancellations are **IRREVOCABLE.**

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

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

_____ _____
Signature **Date**

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 33128-1979
Fax: 305-375-1633 or 305-375-1368