



# 2023 OPEN ENROLLMENT ELECTION FORM FOR GROUP DENTAL PLANS

EMPLOYEE ID NUMBER

|  |  |  |  |  |  |  |  |  |  |
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(\*Please refer to INSTRUCTIONS on reverse side) Any person who knowingly and with intent to injure, defraud, or deceive any Insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Florida Statutes Section 817.234 (1) (b)

|                          |                                     |                          |                           |                 |  |    |                                       |                                 |
|--------------------------|-------------------------------------|--------------------------|---------------------------|-----------------|--|----|---------------------------------------|---------------------------------|
| LAST NAME                |                                     |                          | FIRST NAME                |                 |  | MI |                                       |                                 |
| ADDRESS                  |                                     |                          |                           | CITY            |  |    | STATE                                 | ZIP CODE                        |
| DATE OF BIRTH (MMDDYYYY) |                                     | HOME PHONE               |                           | WORK PHONE      |  |    | GENDER: <input type="checkbox"/> MALE | <input type="checkbox"/> FEMALE |
| DEPARTMENT               |                                     |                          |                           | EMPLOYEE STATUS |  |    | DATE OF HIRE (MMDDYYYY)               |                                 |
| CHANGE TYPE:             | OPEN ENROLLMENT                     | NEW HIRE                 | EFFECTIVE DATE (MMDDYYYY) |                 |  |    | BARGAINING UNIT                       |                                 |
|                          | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                           |                 |  |    |                                       |                                 |

**1. DENTAL** - Select your dental plan/enrollment level for 2023: Decline dental coverage for 2023

|                        | STANDARD DENTAL                  |                                 | ENRICHED DENTAL                  |                                 |
|------------------------|----------------------------------|---------------------------------|----------------------------------|---------------------------------|
|                        | DELTA DENTAL IMDEMNITY/PPO       | DELTACARE USA DHMO (IN-NETWORK) | DELTA DENTAL IMDEMNITY/PPO       | DELTACARE USA DHMO (IN-NETWORK) |
| Employee Only          | <input type="checkbox"/> \$0.00  | <input type="checkbox"/> \$0.00 | <input type="checkbox"/> \$5.19  | <input type="checkbox"/> \$5.56 |
| Employee + 1 Dependent | <input type="checkbox"/> \$12.46 | <input type="checkbox"/> \$3.00 | <input type="checkbox"/> \$22.70 | <input type="checkbox"/> \$3.97 |
| Employee + Family      | <input type="checkbox"/> \$27.86 | <input type="checkbox"/> \$7.04 | <input type="checkbox"/> \$44.40 | <input type="checkbox"/> \$9.02 |

**2. DEPENDENT INFORMATION** – If you made any changes for 2023, complete for all dependents to be covered. If you have any additional children to cover, mark here  and list on a separate sheet. Are any of the dependents listed below new for 2023? YES  NO

| LAST NAME               | FIRST NAME | SOCIAL SEC # | DOB MMDDYYYY | SEX  | Dental |
|-------------------------|------------|--------------|--------------|--|--------|
| Employee                |            |              |              | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |        |
| Spouse/Domestic Partner |            |              |              | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |        |
| Child                   |            |              |              | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |        |
| Child                   |            |              |              | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |        |
| Child                   |            |              |              | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |        |

**3. MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS ON THE REVERSE SIDE OF THIS APPLICATION.**

|           |      |
|-----------|------|
| Signature | Date |
|-----------|------|

## IMPORTANT NOTICE – THIS BENEFIT ELECTION FORM IS TO BE USED ONLY UNDER SPECIAL CIRCUMSTANCES

All benefit plan elections and changes must be submitted online through the Employee Portal (<https://secure.miamidade.gov/employee/home.page>). Outside of the annual open enrollment period (Oct-Nov) or the new hire eligibility period, the only mid-year status changes permitted are those that conform to IRS Section 125 qualifying event rules. For more information refer to the Change in Status (CIS) forms at <https://www.miamidade.gov/global/humanresources/benefits/home.page>.

**Opting-Out or Cancelling Coverage:** If you opt-out or cancel coverage, you cannot re-apply until the next open enrollment, unless you experience a family status or HIPAA qualifying event. The decision to waive coverage has consequences. Declining County medical coverage without enrolling in another group or marketplace health plan may result in a tax penalty. Go to [www.Healthcare.gov](http://www.Healthcare.gov) for additional information regarding the Affordable Care Act's individual mandate.

### GROUP DENTAL PLANS

1. Complete this section to select your dental coverage. To add or change coverage, mark the appropriate box indicating the plan and enrollment level you are electing. Adding or deleting dependents from your plan is considered a change.
2. If you made any changes to your dental plan, list in this section:
  - Yourself and all dependents to be covered in the dental plan. For each dependent listed provide social security #, sex, and date of birth. Check appropriate column to indicate those enrollees who will be covered for medical, dental and/or vision coverage
  - New enrollees must enter their participating provider's ID#, if enrolling in the DeltaCare USA DHMO dental plan.
3. Carefully read the section below marked "Important Terms and Conditions", then sign and date your forms. Make a copy and retain for your records.

### IMPORTANT TERMS AND CONDITIONS

- I authorize my employer to deduct from my pay the cost of any pre and post-tax benefits I have elected. I understand the contribution to my Social Security account may be reduced for pre-tax contributions based on my income after reduction.
- I also agree to pay any return check service fees charged in accordance with Florida Statute 832.07 if, while on an unpaid leave of absence, my personal check is returned unpaid by the Bank.
- I agree for myself and covered members of my family to be bound by the benefits, deductibles, co-payments, exclusions, limitations and other terms of the Contracts, Agreements, and Plan Documents. I understand that my Group Health premiums will automatically be paid tax-free through salary reduction. Any premium attributable to a domestic partner and their child (ren) or children after the calendar year in which they turn age 26 will be post tax and subject to imputed income tax.
- I certify that the information supplied in this application is true to the best of my knowledge.
- I understand that once this form is submitted, I cannot request a change of medical, dental or vision plan carriers until the next annual open enrollment. A change of coverage type may be requested to add a newly acquired dependent within 45 days of the event (60 days for newborns, adoptions/placement for adoption), or to add or delete existing dependents subject to the requirements of Flexible Benefits and HIPAA. Please refer to the online Benefits Guide for specifics.
- I agree to complete and submit to any provider of health services such consents, release, and other assignments as are reasonably necessary in accordance with its rights under the health benefit plans or Insurance policies. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review. In addition, I authorize any provider of health services to release information concerning the health, condition, or treatment of any covered person, upon written request, whenever such information is considered necessary for the proper disposition of a claim submitted for payment, or in fulfillment of obligations.
- I understand that eligible married or unmarried, natural children (whether or not they live with the employee), children of a domestic partner, adopted children, stepchildren may be covered by the medical plan to the end of the calendar year in which the child turns 26 (providing dependent is not offered coverage at work). Proof of eligibility must be submitted to the health plan. Eligibility documents may be forwarded to the DPR for submission to the health plan. For unmarried children who satisfy the criteria under Florida Statute 627.6562, medical coverage may also be extended to the end of the calendar year the child turns 30. To enroll a new dependent child age 26+ to 29, proof of prior health coverage without a break of more than 63 days, is required. **Note:** For the dental, vision, and legal plans the limiting age for unmarried dependent children is the end of the calendar year the dependent reaches age 26 (end of the calendar year), effective 01/01/16. Physically or mentally disabled dependents may continue coverage beyond the limiting age, upon receipt of acceptable medical evidence as requested by the plans. Employees must contact the plan regarding extension of benefits for disabled dependents.
- I agree to submit proof of eligibility to the health plan for all dependent(s) enrolled. In addition, I will submit on an annual basis for each dependent child enrolled age 26+ to 29: 1) Affidavit of Eligibility and 2) Proof of Florida residency, or student status. My dependent (s) will not be enrolled without the legal documentation. Premiums attributable to a domestic partner or their children will be deducted post tax and subject to imputed income tax.

### NEW HIRES

I understand that for ALL dependents to be enrolled, legal documents (example: marriage certificate, birth certificate, certificate of domestic partnership, etc.) must be attached to this form and submitted to Human Resources Dept./ Benefits Administration. The following documents are required to enroll a dependent age 26 to age 29: 1) Affidavit of Eligibility and 2) Proof of Florida residency, or student status. My dependent (s) will not be enrolled without acceptable documentation.