



2016 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"/> \$ 576.49	<input type="checkbox"/> \$ 645.55	<input type="checkbox"/> \$ 280.59
Retiree over 65 & Spouse/Domestic Partner Over 65		<input type="checkbox"/> \$ 1245.96	<input type="checkbox"/> \$ 541.59
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed POS Plan		<input type="checkbox"/> \$ 1810.78	<input type="checkbox"/> \$ 1445.82
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed High Opt. HMO		<input type="checkbox"/> \$ 1135.85	<input type="checkbox"/> \$ 770.89
Retiree over 65 & Child(ren) on AvMed High Opt. HMO		<input type="checkbox"/> \$ 1166.24	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan		<input type="checkbox"/> \$ 2239.52	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO		<input type="checkbox"/> \$ 1514.92	<input type="checkbox"/> \$ 1149.96
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed Select Network HMO		<input type="checkbox"/> \$ 1439.09	

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"/> \$ 1165.23	<input type="checkbox"/> \$ 490.30	<input type="checkbox"/> \$ 441.65	<input type="checkbox"/> \$ 409.35
Child(ren)		<input type="checkbox"/> \$ 520.69	<input type="checkbox"/> \$ 474.79	<input type="checkbox"/> \$ 444.29
Spouse/Domestic Partner Under 65 and Child(ren)	<input type="checkbox"/> \$ 2168.07	<input type="checkbox"/> \$ 1,010.99	<input type="checkbox"/> \$ 916.44	<input type="checkbox"/> \$ 853.64

*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 Plan		MetLife* DHMO (Safeguard)		Humana* - Oral Health Services	
	Standard	Enriched	Standard	Enriched	Standard	Enriched
Retiree Only	<input type="checkbox"/> \$ 31.22	<input type="checkbox"/> \$ 40.87	<input type="checkbox"/> \$ 11.51	<input type="checkbox"/> \$ 16.76	<input type="checkbox"/> \$ 8.00	<input type="checkbox"/> \$ 14.82
Retiree & one dependent	<input type="checkbox"/> \$ 61.76	<input type="checkbox"/> \$ 80.80	<input type="checkbox"/> \$ 19.02	<input type="checkbox"/> \$ 27.77	<input type="checkbox"/> \$ 13.24	<input type="checkbox"/> \$ 24.58
Retiree & dependents	<input type="checkbox"/> \$ 99.55	<input type="checkbox"/> \$ 130.30	<input type="checkbox"/> \$ 29.11	<input type="checkbox"/> \$ 44.15	<input type="checkbox"/> \$ 20.22	<input type="checkbox"/> \$ 39.02

*MetLife DHMO and Humana-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 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

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>

Initials _____

Signature _____

Date _____

FOR OFFICE USE ONLY - EG - EI - INV

FRS IPDAF: _____ Needed _____ Not Needed

Basic Life Conv. Amount \$ _____

Conv. Letter: Yes _____ No _____

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