2018 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	☐ $ 675.52	☐ $ 756.45	☐ $ 328.80
Retiree over 65 & Spouse/Domestic Partner Over 65	☐ $1,282.37	☐ $1,435.94	☐ $ 624.17
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed POS Plan		☐ $2,075.54	☐ $1,647.89
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed High Opt. HMO		☐ $1,326.33	☐ $ 898.68
Retiree over 65 & Child(ren) on AvMed High Opt. HMO		☐ $1,352.28	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan		☐ $2,594.18	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO		☐ $1,749.97	☐ $1,322.32
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed Select Network HMO		☐ $1,665.43	

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	☐ $ 1,319.09	☐ $ 569.88	☐ $ 515.69	☐ $ 479.68
Child(ren)		☐ $ 595.83	☐ $ 544.64	
Spouse/Domestic Partner Under 65 and Child(ren)	☐ $ 2,436.54	☐ $1,165.71	☐ $1,060.33	

**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	☐ $ 29.03	☐ $ 40.87	☐ $ 10.08	☐ $ 11.29
Retiree & one dependent	☐ $ 57.44	☐ $ 80.80	☐ $ 16.65	☐ $ 18.72
Retiree & dependents	☐ $ 92.58	☐ $ 130.30	☐ $ 25.48	☐ $ 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**
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ 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	☐ $ 11.03	☐ $ 18.20	☐ $ 25.16
$20,000	☐ $ 14.70	☐ $ 24.26	☐ $ 33.54

_____ 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: Ret. Type:
Longevity: FRS _____ County _____ Other Remarks:_____

Please sign, date, and mail or fax this form to:
Miami-Dade County
Human Resources - Benefits Division
111 NW 1st Street, Suite 2324
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368