2018 NEW RETIREE INSURANCE BENEFITS ELECTION FORM

*For **Retirees Under Age 65***

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	AvMed POS	AvMed High Opt HMO	AvMed MDC Select Network HMO*	AvMed MDC Jackson First HMO*
Retiree or Spouse/Domestic Partner Under 65	☐ $1,319.09	☐ $ 569.88	☐ $ 515.69	☐ $ 479.68
Retiree Under 65 & Spouse/Domestic Partner Under 65	☐ $2,547.02	☐ $1,264.64	☐ $1,150.91	☐ $1,075.36
Retiree Under 65& Child(ren)	☐ $2,436.54	☐ $1,165.71	☐ $1,060.33	☐ $ 990.34
Retiree Under 65 & Spouse/Domestic Partner Under 65, plus Child(ren)	☐ $3,156.82	☐ $1,563.40	☐ $1,424.67	☐ $1,332.50

**AvMed Plans not available outside Miami-Dade, Broward & Palm Beach Counties*

Retiree Under 65 & Spouse/DP Medicare Eligible

Monthly Rates (Must be enrolled in Medicare Parts A and B to be eligible for any of the AvMed over 65 plans)	AvMed POS	AvMed High Opt HMO	AvMed MDC Select Network HMO*	AvMed MDC Jackson First HMO*
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible - High Opt Plan	☐ $ 2,075.54	☐ $ 1,326.33	☐ $ 1,272.14	
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible - No RX Plan		☐ $ 898.68		

**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 the 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

The value of the Miami-Dade County Retiree Group Life Insurance Policy is **one-time your base annual salary** at the time of retirement. The 2018 rate is **20.5 cents per thousand** dollars per month.

_____ 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