2025 MDC BENEFITS ELECTION FORM FOR GROUP HEALTH PLANS

(*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)

SOCIAL SECURITY OR EMPLOYEE ID NUMBER

LAST NAME		FIRST NAME		MI
ADDRESS		CITY	STATE	ZIP CODE
DATE OF BIRTH (MMDDYYYY)	HOME PHONE	WORK PHONE	GENDER: MALE ☐	FEMALE ☐
DEPARTMENT		EMPLOYEE STATUS	DATE OF HIRE (MMDDYYYY)	
CHANGE TYPE: NEW HIRE ☐	CHANGE IN STATUS ☐	EFFECTIVE DATE (MMDDYYYY)	BARGAINING UNIT	

GROUP HEALTH PLANS (RATES INDICATED ARE BIWEEKLY)

1. MEDICAL - Select your medical plan/enrollment level for 2025: *Opt-Out/Decline medical coverage for 2025 ☐ Refer to reverse side

	SELECT ADVANTAGE HMO	FIRST CHOICE ADVANTAGE HMO
Employee Only	☐ $0.00	☐ $0.00
Employee + Child(ren)	☐ $141.00	☐ $112.02
Employee + Spouse/ Domestic Partner	☐ $166.00	☐ $134.71
Employee + Family	☐ $236.00	☐ $197.84

2. DENTAL - Select your dental plan/enrollment level for 2025: Decline dental coverage for 2025 ☐

	STANDARD DENTAL		ENRICHED DENTAL	
	DELTA DENTAL INDEMNITY/PPO*	DELTACARE USA DHMO (IN-NETWORK)*	DELTA DENTAL INDEMNITY/PPO*	DELTACARE USA DHMO (IN-NETWORK)*
Employee Only	☐ $0.00	☐ $0.00	☐ $5.19	☐ $.56
Employee + 1 Dependent	☐ $12.46	☐ $3.00	☐ $22.70	☐ $3.97
Employee + Family	☐ $27.86	☐ $7.04	☐ $44.40	☐ $9.02

3. Humana VISION PLAN Select plan and enrollment level for 2025: Decline vision coverage for 2025 ☐

STANDARD VISION: Employee Only ☐ $3.40 Employee + 1 Dependent ☐ $6.79 Employee + Family ☐ $12.20

ENRICHED VISION: Employee Only ☐ $4.19 Employee + 1 Dependent ☐ $8.38 Employee + Family ☐ $15.41

4. DEPENDENT INFORMATION – If you made any changes for 2025, 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 2025? YES ☐ NO ☐

LAST NAME	FIRST NAME	SOCIAL SEC #	DOB MMDDYYYY	SEX	Medical	Dental	Vision
Employee				☐ Male ☐ Female			
Spouse/Domestic Partner				☐ Male ☐ Female			
Child				☐ Male ☐ Female			
Child				☐ Male ☐ Female			
Child				☐ Male ☐ Female			

5. 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 for additional information regarding the Affordable Care Act's individual mandate.

GROUP MEDICAL, DENTAL PLANS AND VISION PLAN

1. Complete this section to select your medical 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. 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.

3. Complete this section to select vision coverage. If you wish to make a change {ex., add or delete dependents, enroll for coverage or cancel coverage), please complete this section. This plan is available to all eligible employees regardless of Union affiliation.

4. If you made any changes to your medical, dental or vision plans, list in this section:
   - Yourself and all dependents to be covered in the medical, dental or vision plans. 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.

5. 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 Stature 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 (12/31/XXXX) in which the dependent reaches age 26. 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.

2025 MDC BENEFITS ELECTION FORM FOR GROUP LEGAL INSURANCE, DISABILITY INCOME PROTECTION AND FLEXIBLE BENEFITS

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SOCIAL SECURITY OR EMPLOYEE ID#

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DATE OF BIRTH (MMDDYYYY)	HOME PHONE	WORK PHONE	GENDER: MALE ☐	FEMALE ☐
DEPARTMENT		EMPLOYEE STATUS	DATE OF HIRE (MMDDYYYY)	
CHANGE TYPE: OPEN ENROLLMENT ✓	NEW HIRE ☐	EFFECTIVE DATE (MMDDYYYY) **1/1/2025**	BARGAINING UNIT	

ALL RATES ARE BIWEEKLY, EXCEPT IN SECTION 8

GROUP LEGAL INSURANCE (After tax)

6. Complete only if you wish to enroll or make a change to your Group Legal Plan for 2025. Decline Group Legal for 2025 ☐

☐ Employee Only	$7.29
☐ Employee + 1 Dependent	$9.34
☐ Employee + Dependents	$9.61

DISABILITY INCOME PROTECTION (After tax)

7. Complete only if you wish to enroll or make a change for 2025

METLIFE STD	Premium Per $100 Weekly Benefit	METLIFE LTD	Premium Per $100 of Covered Monthly Payroll
Low Option ($500 max weekly benefit)	☐ $1.45	Low Option ($2,000 max monthly benefit)	☐ $0.175
High Option ($1,000 max weekly benefit)	☐ $1.45	High Option ($4,000 max monthly benefit)	☐ $0.210
		Premier Plan ($7,000 max mo. benefit)	☐ $0.292

Employee must be actively at work for new disability coverage to take effect.

Decline STD coverage for 2025 ☐ Decline LTD coverage for 2025 ☐

SPENDING ACCOUNTS

8. Complete if you wish to participate in either or both Flexible Spending Accounts for 2025. You must complete this section by entering the **ANNUAL DOLLAR AMOUNT**. Participation does no carryover from the previous year; you must re-enroll during open enrollment.

A. HEALTH CARE SPENDING ACCOUNT	B. DEPENDENT CARE SPENDING ACCOUNT
$ | | | | | . | |	$ | | | | | . | |

Example: $500.00

$| |**5**|**0**|**0**|. | 0|0

IMPORTANT - These benefits apply to plan year 2025 only. The County necessarily reserves the right to amend or terminate any of the benefits at any time.

I certify that the information supplied in this application is true to the best of my knowledge. I hereby authorize my employer to reduce my gross salary before Federal and Social Security taxes are calculated by the total amount of annual salary reduction indicated above in the election I made in Section 8. I hereby authorize my employer to deduct from my pay any benefits I have elected on an after-tax basis. I understand that the cost of disability income protection plan(s) for plan year 2025 will be based on salary and option(s) selected. I understand the contribution to my Social Security account may be reduced if contributions will be based on my income after reduction. I understand that the funds in the Spending Accounts can be used only to reimburse payment of eligible expenses incurred during the plan year or the grace period, if applicable and while participating in the plan. Any amount remaining in a Spending Account that is not used during this period will be forfeited. Expenses for a Domestic Partner and their children are not reimbursable. Also, expenses for overage children who meet the criteria of FSS 627.6562 are not reimbursable. I understand that the funds in the Spending Accounts cannot be used to reimburse expenses covered by another plan. I understand that expenses for which I am reimbursed cannot be claimed on my income tax returns or eligible for coverage under any other insurance plan. I understand that the amount of salary reduction will include the items specified above and will continue in effect throughout 2025 unless I terminate employment or file an approved Change in Status before the end of the year. I understand and agree that my employer and benefit plans will not incur any liability resulting for my failure to sign or accurately complete this election form.

9. FEES will be charged where applicable, see reverse side for amounts. 10. My signature below certifies I have read and agree to the terms/conditions above.

Signature	Date

INSTRUCTIONS

Fill each bubble completely Example: ■

- Erase completely to change
- Make a copy of this form for your records.
- Please read your Benefits Guide carefully to make informed choices

Report any changes to your personal information located at the top of your form to your DPR.

IMPORTANT NOTICE TO NEW HIRES:

You must go online to eNet to enroll for your initial benefits and to designate your life insurance beneficiary (ies).

6. **GROUP LEGAL INSURANCE**

Complete this section to select Group Legal Insurance coverage. To add or change coverage, mark the appropriate box indicating the enrollment level you are electing. Adding or deleting dependents from your plan is considered a change. Cover only those dependents who may utilize this plan.

7. **DISABILITY INCOME PROTECTION**

Review your current coverage. Add and/or cancel the coverage you want by marking the appropriate box(es).

STD Low Option: Biweekly Premium = Adj. Biweekly Salary (capped at $1,666.67) ÷ 2 x 0.60 x 0.0145
STD High Option: Biweekly Premium = Adj. Biweekly Salary (capped at $3,333.34) ÷ 2 x 0.60 x 0.0145
LTD Low Option: Biweekly Premium = Adj. Biweekly Salary (capped at $1,538.76) x 26 ÷ 12 x 0.00175
LTD High Option: Biweekly Premium = Adj. Biweekly Salary (capped at $3,077.52) x 26 ÷ 12 x 0.00210
Premier LTD: Biweekly Premium = Adj. Biweekly Salary (capped at $4,846.16) x 26 ÷ 12 x 0.00292

Enrollment in the Premier LTD Plan cannot be combined with the regular STD and LTD Plans. You may enroll for STD and/or regular LTD coverage, or enroll in the Premier LTD Plan alone. The plans are mutually exclusive due to the overlap in the elimination periods.
(Visit the online calculator@ https://secure.miamidade.gov/employee/benefits/disability-insurance.page)

8. **FLEXIBLE BENEFITS PLAN**

Review your current elections. You must complete this section if you wish to participate in either or both Spending Accounts. Participation does no carryover from the previous year; you must re-enroll during open enrollment. Write the annual amount in the boxes provided.

A. Healthcare Spending Account
- Minimum annual contribution: $260 for the full plan year
- Maximum annual contribution: $3,200 for the full plan year

B. Dependent Care Spending Account
- Minimum annual contribution: $260 for the full plan year
- Maximum varies depending on your tax filing status:
  - Married, filing separately, maximum: $2,500 for the full plan year
  - Married, filing jointly, maximum: $5,000 for the full plan year
  - Single, head of household, maximum: $5,000 for the full plan year

9. **FEES**

The biweekly administrative fees are as follows:
- Health Care Spending Account $ 0.00
- Dependent Care Spending Account $ 0.00
- Maximum Biweekly fee for one account or both FSA accounts combined: $ 0.00 ($0.00 annually)

10. Carefully read the section marked "Important." If you made any changes to your benefits or you are participating in a Flexible Spending Account(s), please sign, date and return your form.