2021 NEW RETIREE INSURANCE BENEFITS ELECTION FORM

*For **Retirees Over Age 65 and/or Medicare** Eligible*

This form must be received by the Benefits Administration Unit no later than thirty (30) days following your retirement date, otherwise you forfeit Retiree Group coverage.

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 High With RX**	**AvMed High W/O RX**
Retiree over 65 Only	☐ $ 812.87	☐ $ 353.33
Retiree over 65 & Spouse/Domestic Partner Over 65	☐ $1,532.60	☐ $ 666.19
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed POS Plan	☐ $2,368.27	
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed High Opt. HMO	☐ $1,505.01	☐ $1,045.47
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed Select Network HMO*	☐ $1,442.22	
Retiree over 65 & Child(ren) on AvMed High Opt. HMO	☐ $1,524.08	☐ $1,064.54
Retiree over 65 & Child(ren) on AvMed Select Network HMO*	☐ $1,464.85	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan	☐ $3,025.01	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO	☐ $1,997.02	☐ $1,537.48
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed Select Network HMO*	☐ $1,899.19	

**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 PPO℠**		**DeltaCare® 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

VISION COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates for:	**Humana Vision Program**	
	Standard	*Enriched*
Retiree Only	☐ $7.36	☐ $9.08
Retiree & one dependent	☐ $14.72	☐ $18.15
Retiree & dependents	☐ $26.44	☐ $33.38

If medical, dental and/or vision coverage for dependent(s) is selected, please provide the information below.

Name	**Relationship****	**SSN**	**DOB**	**M/F**	**Indicate Coverage Selected**
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision

***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

To update your life insurance beneficiary designation, visit **LifeBenefits.com**

_____ Initials

I am aware that it is my responsibility to read and understand the contents of the Retiree Insurance Benefits Handbook available at https://www8.miamidade.gov/global/humanresources/benefits/retiree-insurance-faqs.page

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 Administration Unit
111 NW 1st Street, Suite 2324
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368