



2024 NEW RETIREE INSURANCE BENEFITS ELECTION FORM

For Retirees Under Age 65

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	AvMed POS	AvMed High Opt HMO	AvMed MDC Select Network HMO*	AvMed MDC Jackson First HMO*
Retiree Under 65	<input type="checkbox"/> \$1,710.94	<input type="checkbox"/> \$ 761.35	<input type="checkbox"/> \$ 692.29	<input type="checkbox"/> \$ 554.72
Retiree Under 65 & Spouse/Domestic Partner Under 65	<input type="checkbox"/> \$3,296.65	<input type="checkbox"/> \$1,673.32	<input type="checkbox"/> \$1,528.48	<input type="checkbox"/> \$1,239.74
Retiree Under 65 & Child(ren)	<input type="checkbox"/> \$3,133.74	<input type="checkbox"/> \$1,543.69	<input type="checkbox"/> \$1,409.46	<input type="checkbox"/> \$1,142.03
Retiree Under 65 & Spouse/Domestic Partner Under 65, plus Child(ren)	<input type="checkbox"/> \$4,144.29	<input type="checkbox"/> \$2,063.92	<input type="checkbox"/> \$1,887.24	<input type="checkbox"/> \$1,535.11
Retiree Under 65 & Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High With RX**		<input type="checkbox"/> \$1,521.90	<input type="checkbox"/> \$1,452.84	
Retiree Under 65 & Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High W/O RX**		<input type="checkbox"/> \$1,091.94		
Retiree Under 65 & Children, Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High With RX**	<input type="checkbox"/> \$3,193.90	<input type="checkbox"/> \$2,063.12	<input type="checkbox"/> \$1,955.50	
Retiree Under 65 & Children, Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High W/O RX**				

*AvMed Plans not available outside Miami-Dade, Broward & Palm Beach Counties - **Must be enrolled in Medicare Parts A and B to be eligible for any of the AvMed over 65 plans

DENTAL COVERAGE

SELECT

DECLINE

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

Monthly Rates	Delta Dental PPO SM		DeltaCare [®] DHMO	
	Standard	Enriched	Standard	Enriched
Retiree Only	<input type="checkbox"/> \$ 27.53	<input type="checkbox"/> \$ 38.78	<input type="checkbox"/> \$ 9.93	<input type="checkbox"/> \$ 11.18
Retiree & one dependent	<input type="checkbox"/> \$ 54.52	<input type="checkbox"/> \$ 76.71	<input type="checkbox"/> \$ 16.43	<input type="checkbox"/> \$ 18.53
Retiree & dependents	<input type="checkbox"/> \$ 87.90	<input type="checkbox"/> \$ 123.74	<input type="checkbox"/> \$ 25.18	<input type="checkbox"/> \$ 29.47

VISION COVERAGE

SELECT

DECLINE

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

Monthly Rates for:	Humana Vision Program	
	Standard	Enriched
Retiree Only	<input type="checkbox"/> \$7.36	<input type="checkbox"/> \$9.08
Retiree & one dependent	<input type="checkbox"/> \$14.72	<input type="checkbox"/> \$18.15
Retiree & dependents	<input type="checkbox"/> \$26.44	<input type="checkbox"/> \$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		
					<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
					<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
					<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision

**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 2024 rate is **17.6 cents per thousand** dollars per month. To update your life insurance beneficiary designation, visit [LifeBenefits.com](https://www.miamidade.gov/global/humanresources/benefits/retiree-insurance-faqs.page).

Initials

I am aware that it is my responsibility to read and understand the contents of the Retiree Insurance Benefits Handbook available at <https://www.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 Division
111 NW 1st Street, Suite 2324
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368