



2020 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"/> \$1,475.00	<input type="checkbox"/> \$ 650.54	<input type="checkbox"/> \$ 590.68	<input type="checkbox"/> \$ 550.94
Retiree Under 65 & Spouse/Domestic Partner Under 65	<input type="checkbox"/> \$2,843.86	<input type="checkbox"/> \$1,433.90	<input type="checkbox"/> \$1,308.34	<input type="checkbox"/> \$1,224.91
Retiree Under 65 & Child(ren)	<input type="checkbox"/> \$2,708.56	<input type="checkbox"/> \$1,322.49	<input type="checkbox"/> \$1,206.12	
Retiree Under 65 & Spouse/Domestic Partner Under 65, plus Child(ren)	<input type="checkbox"/> \$3,559.74	<input type="checkbox"/> \$1,769.82	<input type="checkbox"/> \$1,616.66	
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible on AvMed High With RX**	<input type="checkbox"/> \$2,236.39	<input type="checkbox"/> \$1,411.93	<input type="checkbox"/> \$1,352.07	
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible on AvMed High W/O RX **		<input type="checkbox"/> \$ 981.49		
Retiree under 65 & Children, Spouse/Domestic Partner over 65 and/or Medicare Eligible on AvMed High With RX**	<input type="checkbox"/> \$2,846.13	<input type="checkbox"/> \$1,880.67	<input type="checkbox"/> \$1,787.37	
Retiree under 65 & Children, Spouse/Domestic Partner over 65 and/or Medicare Eligible on AvMed High W/O RX**		<input type="checkbox"/> \$1,450.23		

*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"/> \$ 29.03	<input type="checkbox"/> \$ 40.87	<input type="checkbox"/> \$ 10.08	<input type="checkbox"/> \$ 11.29
Retiree & one dependent	<input type="checkbox"/> \$ 57.44	<input type="checkbox"/> \$ 80.80	<input type="checkbox"/> \$ 16.65	<input type="checkbox"/> \$ 18.72
Retiree & dependents	<input type="checkbox"/> \$ 92.58	<input type="checkbox"/> \$ 130.30	<input type="checkbox"/> \$ 25.48	<input type="checkbox"/> \$ 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
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental
					<input type="checkbox"/> Medical <input type="checkbox"/> 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 2020 rate is **17.6 cents per thousand** dollars per month. To update your life insurance beneficiary designation, visit [LifeBenefits.com](http://www.miamidade.gov/humanresources/retirees.asp).

_____ 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>.
Initials

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