2025 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	☐ $1,948.69	☐ $ 867.14	☐ $ 788.48	☐ $ 631.79
Retiree Under 65 & Spouse/Domestic Partner Under 65	☐ $3,754.72	☐ $1,905.83	☐ $1,740.86	☐ $1,412.01
Retiree Under 65 & Child(ren)	☐ $3,569.19	☐ $1,758.19	☐ $1,605.31	☐ $1,300.72
Retiree Under 65 & Spouse/Domestic Partner Under 65, plus Child(ren)	☐ $4,720.13	☐ $2,350.70	☐ $2,149.48	☐ $1,748.40
Retiree Under 65 & Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High With RX**		☐ $1,627.69	☐ $1,549.03	
Retiree Under 65 & Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High W/O RX **		☐ $1,197.73		
Retiree Under 65 & Children, Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High With RX**	☐ $3,531.99	☐ $2,244.11	☐ $2,121.55	
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℠		DeltaCare® DHMO	
	Standard	*Enriched*	*Standard*	*Enriched*
Retiree Only	☐ $ 27.53	☐ $ 38.78	☐ $ 9.93	☐ $ 11.18
Retiree & one dependent	☐ $ 54.52	☐ $ 76.71	☐ $ 16.43	☐ $ 18.53
Retiree & dependents	☐ $ 87.90	☐ $ 123.74	☐ $ 25.18	☐ $ 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	☐ $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

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 **15.8 cents per thousand** dollars per month. 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://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