2026 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 over 65 plans)*	**Aetna High With RX**	**Aetna High W/O RX**
Retiree Over 65 Only	☐ $803.91	☐ $349.44
Retiree Over 65 & Spouse/Domestic Partner Over 65	☐ $1,517.24	☐ $660.25
Retiree over 65 & Spouse/Domestic Partner Under 65 on Aetna High Opt HMO	☐ $1,723.82	☐ $1,269.35
Retiree over 65 & Children on Aetna High Opt HMO	☐ $1,745.49	☐ $1,291.02
Retiree Over 65 & Spouse/Domestic Partner Over 65, Child(ren) on Aetna POS Plan	☐ $3,217.42	☐ $2,360.00
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on Aetna High Opt. HMO	☐ $2,371.08	☐ $1,916.61
Retiree Over 65 & Spouse/Domestic Partner Under 65 on Aetna Select Network HMO	☐ $1,641.29	☐ $1,186.82
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on Aetna Select Network HMO	☐ $2,242.48	☐ $1,788.01
Retiree Over 65 & Spouse/Domestic Partner Over 65, Child(ren) over 26 on Aetna High Opt. HMO	☐ $2,458.82	☐ $1,601.83
Retiree Over 65 & Spouse/Domestic Partner Over 65, Child(ren) on Aetna Select Network HMO	☐ $2,380.94	☐ $1,523.95
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on Aetna POS Plan	☐ $3,738.13	☐ $3,283.66

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	☐ $28.91	☐ $40.72	☐ $10.43	☐ $11.74
Retiree & one dependent	☐ $57.25	☐ $80.55	☐ $17.25	☐ $19.46
Retiree & dependents	☐ $92.30	☐ $129.93	☐ $26.44	☐ $30.94

VISION COVERAGE ☐ SELECT ☐ DECLINE

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

Monthly Rates	**Humana Vision Program**	
	Standard	*Enriched*
Retiree Only	☐ $7.36	☐ $13.39
Retiree & one dependent	☐ $14.72	☐ $26.76
Retiree & dependents	☐ $26.44	☐ $49.22

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

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**

_____ 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/retirees.page.

Initial

_____ _____

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 - People and Internal Operations Dept
Benefits Administration Division
111 NW 1st Street, Suite 2324
Miami, FL 33128-1979
Fax: 305-375-1368