# Retiree Group Insurance Benefits

## *Change In Status (CIS) Form*

**Retiree Name:** _____ **Telephone Number:** _____ **ID:** _____

**Address:** _____ **City:** _____**State:** _____ **Zip:** _____

**INDICATE THE TYPE OF MID YEAR PLAN QUALIFYING EVENT (QE) INCURRED:**

| **ADDITIONS** | **Documentation Required** |
|---|---|
| ☐ Marriage/Domestic Partnership (DP) | Marriage Certificate / DP Certificate |
| ☐ Birth of a child (60 days for newborns) | Birth Certificate (when it becomes available) |
| ☐ Adoption of or placement for adoption of child | Finalized adoption agreement or letter from placement agency |
| ☐ End of employment of spouse/dependent | Letter of explanation from employer with cancellation date of coverage |
| **CANCELLATIONS: All Cancellations are Irrevocable (Once cancelled, coverage will not be reinstated, even if a qualifying event occurs in the future). The earliest indicated coverage can be cancelled is at the end of the month in which this request is received in our office. Premiums must be paid through the cancellation date.** | |
| ☐ Divorce | Divorce Decree |
| ☐ Termination of Domestic Partnership | Letter Certifying the Termination of Domestic Partnership |
| ☐ Death (dependent) child or spouse/DP | Death Certificate |
| ☐ Ineligibility of dependent child: ☐ Age ☐ Marriage | Marriage Certificate |
| ☐ Medicare | Copy of Medicare card showing effective date |
| ☐ Other/Voluntary | |
| **CHANGES** | |
| ☐ Change in Residence. New address:_____ _____ | Utility Bill, change in address form, lease, mortgage agreement |

**INDICATE THE CHANGE(S) YOU WISH TO MAKE DUE TO THE MID YEAR PLAN QUALIFYING EVENT INDICATED ABOVE. PERMITTED ELECTION CHANGES MUST BE CONSISTENT WITH THE QUALIFYING EVENT.**

| **Retiree Group Medical Insurance** | **Retiree Group Dental Insurance** | **Retiree Group Life Insurance** |
|---|---|---|
| ☐ Add Medical coverage for spouse/DP<br>☐ Add Medical coverage for child(ren) | ☐ Add Dental coverage for spouse/DP<br>☐ Add Dental coverage for child(ren) | |
| ☐ Cancel Medical coverage<br>☐ Cancel Medical coverage for spouse/DP<br>☐ Cancel Medical coverage for child(ren) | ☐ Cancel Dental coverage<br>☐ Cancel Dental Coverage of spouse/DP<br>☐ Cancel Dental Coverage of Child(ren) | ☐ Cancel Life Insurance Coverage (Self) |
| ☐ Change Medical Coverage from: _____ _____ to _____ (Midyear upgrade is only permitted if new address is out the Tri-County area) | ☐ Change Dental Coverage from DHMO to DPPO (Midyear upgrade is only permitted if new address is out the Tri-County area) | |

**IF ADDING OR CANCELING MEDICAL AND/OR DENTAL COVERAGE FOR DEPENDENT(S) PLEASE PROVIDE THE INFORMATION BELOW.**

| **Name** | **Relationship*** | **SSN** | **DOB** | **M/F** | **Indicate Coverage to be Added/cancelled** |
|---|---|---|---|---|---|
| | | | | | ☐ Medical ☐ Dental |
| | | | | | ☐ Medical ☐ Dental |
| | | | | | ☐ Medical ☐ Dental |

**SP- Spouse, CH-Child, DP-Domestic Partner, DPCH- Child of Domestic Partner*

This is to certify that on_____, 20_____ I incurred the events indicated above and therefore wish to modify my retiree benefits effective _____. I understand that the change(s) requested must be consistent with the qualifying event and that I must submit this form with supporting documentation within 45 days (60 days for newborns) of the qualifying event.

_____
Signature

_____
Date

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: 305-375-1368