MIAMIBEACH

City of Miami Beach Group Health Change Form

Retiree

For Benefit Office use only
Grp #: Medical_____ Dental_____

Ben #: Medical_____

Class/Division _____

General Information

Last Name | First Name | MI

Social Security Number ___ - __ - ____ | City ID Number

Street Address | Apt/Suite/PO box number

City | State | Zip Code | County

- ☐ Add dependent (complete Dependent information form and any applicable enrollment forms).
- ☐ Delete dependent (complete Dependent information form and any applicable enrollment forms).
- ☐ Cancel coverage effective _____/_____/ 20_____ .

Qualifying Life Event

Qualifying Life Event:

- ☐ Marriage/Domestic Partner (must provide copy of Marriage License or Certificate. Must be newly registered Domestic Partner.)
- ☐ Birth or adoption (must provide copy of footprint, birth certificate, certificate of adoption or proof of placement in your home for adoption.)
- ☐ Divorce/ Legal Separation (must provide copy of divorce or separation agreement.)
- ☐ Spouse's employer terminates or no longer contributes to coverage
- ☐ Spouse change from full-time to part-time employment
- ☐ Spouse terminates employment
- ☐ Dependent's death
- ☐ Other

Date of Qualifying Life Event (MM/DD/YYYY)

_____/_____/ 20_____

Medical – Does not apply to Police and Fire Employees.

Change Plan from:

Coverage Type ☐ Premium HMO ☐ Standard HMO ☐ Premium PPO

☐ Standard PPO ☐ POS ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Family ☐ No Coverage

Change Plan To:

Coverage Type ☐ Premium HMO ☐ Standard HMO ☐ Premium PPO

☐ Standard PPO ☐ POS ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Family ☐ No Coverage

Dental– Does not apply to Fire Employees

Change Plan from:

Coverage Type ☐ DHMO ☐ PPO ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Employee + 1 ☐ Family

Change Plan To:

Coverage Type ☐ DHMO ☐ PPO ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Employee + 1 ☐ Family ☐ No Coverage

Dependent Information – Please enter information for each dependent you wish to enroll for coverage. For additional dependents, copy and attach an additional dependent information form. **You must provide proof of dependency and the birthdates and Social Security number of each dependent you wish to enroll. Dependents will not be enrolled if this information is missing**

1. Add ☐ Change ☐ Delete ☐

Plan ☐ Medical ☐ Dental ☐ Dependent Life Insurance

Last Name | First Name | MI

Social Security Number | Date of Birth (MMDDYYYY) | Relationship Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐ Relationship Spouse ☐ Child ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No ☐

Primary Care Physician (HMO and POS Only) Physician ID Current Patient? Yes ☐ No ☐

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2. Add ☐ Change ☐ Delete ☐

Plan ☐ Medical ☐ Dental ☐ Dependent Life Insurance

Last Name | First Name | M

Social Security Number | Date of Birth (MMDDYYYY) | Relationship Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐ Relationship Spouse ☐ Child ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No

Primary Care Physician (HMO and POS Only) Physician ID Current Patient? Yes ☐ No ☐

3. Add ☐ Change ☐ Delete ☐

Plan ☐ Medical ☐ Dental ☐ Dependent Life Insurance

Last Name | First Name | M

Social Security Number | Date of Birth (MMDDYYYY) | Relationship Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐ Relationship Spouse ☐ Child ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No

Primary Care Physician (HMO and POS Only) Physician ID Current Patient? Yes ☐ No ☐

Compensation Reduction Agreement

I agree that my pay will be reduced by the amount of my required contribution for the benefit option(s) I have electec The amount of my required bi-weekly contributions for each benefit option I have elected has been provided to me b Human Resources. I also understand the following:

- My premium contributions are taken from my payroll before taxes are calculated. I understand I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next Annual Ope Enrollment, unless I have a qualified change in family status (qualified life event) such as the birth or adoption of a child, marriage, divorce, death of my spouse, a reduction in hours, or termination of my spouse's employment. Eligibility for Medicare for my spouse or me does not constitute a qualified life event. I will notify Employee Benefits within **30 days of the qualifying event** to make any necessary changes to my elected coverage. I alsc understand documentation will be required for verification.
- The establishment of and my subsequent participation in a union sponsored medical or dental plan during the plan year will not change my plan participation at that time.
- If my required contributions for my elected benefits are increased or decreased while this agreement remains in effect, my pay will automatically be adjusted to reflect the increase or decrease in premium.
- During the Annual Open Enrollment each year I will be provided the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return an election form during that time, I will be treated as having elected to continue the benefit coverage then in effect and the associated required contributions, unless otherwise required by the City.
- The Plan Administrator may reduce or cancel the amount of my payroll contributions or otherwise modify this agreement if the Administrator believes it is advisable in order to satisfy provision or changes in the provisions o the Internal Revenue Code.
- I am responsible for the associated contributions for all the benefit coverage I elect, and understand my coverag elections may be terminated should my bi-weekly compensation be reduced to a level insufficient to cover the cost of my elected coverage.
- The reduction in my cash compensation under this agreement will be in addition to any other reduction under an other agreements or benefit plans.
- I understand that any misrepresentation of the eligibility of my dependents may result in my loss of eligibility under the City of Miami Beach Group Health Plan and may also result in disciplinary action up to and including termination of my employment.

Signature

Employee Signature	Date

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