MIAMIBEACH

City of Miami Beach Group Health Change Form 2024/2025 General Retirees

Effective Date:

General Information

Last Name | First Name | MI

Social Security Number / / | City ID | Date of Birth (MM/DD/YYYY) / / | Gender M F

Daytime Phone - - Ext. | Evening Phone - -

Street Address | Apt/Suite/PO Box Number

City | State | Zip Code

Medical - Retirees who are enrolled in the PPO during the 2018-2019 plan year may remain enrolled in this health plan option. However no new enrollees may enroll in the PPO health plan option

Change Plan from:

Carrier ☐ Cigna ☐ No Coverage

Coverage Type ☐ Open Access In-Network ☐ PPO ☐ High Deductible Health Plan

Coverage Level ☐ Employee Only ☐ Employee +1 ☐ Family

Change Plan To:

Carrier ☐ Cigna ☐ No Coverage

Coverage Type ☐ Open Access In-Network ☐ PPO ☐ High Deductible Health Plan

Coverage Level ☐ Employee Only ☐ Employee +1 ☐ Family

Dental

Change Plan from:

Coverage Type ☐ Cigna DHMO ☐ Cigna DPPO ☐ No Coverage

DHMO Office # _____

Coverage Level ☐ Employee Only ☐ Employee +1 ☐ Family

Change Plan to:

Coverage Type ☐ Cigna DHMO ☐ Cigna DPPO ☐ No Coverage

DHMO Office # _____

Coverage Level ☐ Employee Only ☐ Employee +1 ☐ Family

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 social security number of each dependent. Dependents will not be enrolled if this information is missing**

1. Plan ☐ **Medical** ☐ **Dental** **Action:** ☐ **Add** ☐ **Change** ☐ **Delete**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

2. Plan ☐ **Medical** ☐ **Dental** **Action:** ☐ **Add** ☐ **Change** ☐ **Delete**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

3. Plan ☐ **Medical** ☐ **Dental** **Action:** ☐ **Add** ☐ **Change** ☐ **Delete**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

Coordination of Benefits - The City of Miami Beach Group Health Plan coordinates coverage with any other health coverage you may have, including Medicare. Please indicate any other health coverage you may have at this time.

Will you have any other group medical coverage, including Medicare, in effect at the same time as this coverage?

Yes ☐ No ☐

If yes, Plan name_____

Policy Number_____ Phone_____

Medicare ID_____ Effective date_____ Termination Date_____

Compensation Reduction Agreement

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

- I understand I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next Annual Open 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 will notify Employee Benefits within **45 days of the qualifying event** to make any necessary changes to my elected coverage. I also understand documentation will be required for verification.
- If my required contributions for my elected benefits are increased or decreased while this agreement remains in effect, my pension payment 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 of the Internal Revenue Code.
- I am responsible for the associated contributions for all the benefit coverage I elect, and understand my coverage elections may be terminated should my pension payment be reduced to a level insufficient to cover the cost of my elected coverage.
- 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.

Signature

Retiree Signature	**Date**