MIAMIBEACH

City of Miami Beach Group Health
2017/18 Annual Open Enrollment
General Employees

Coverage Effective Date:

October 1, 2017

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 | Date of Hire (MM/DD/YYYY) / /

Medical - Not applicable to Fire and Police Employees.

Carrier Cigna ☐ No Coverage *

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

Coverage Level ☐ Employee Only ☐ Employee +1 ☐ Family

* Having met the eligibility requirements, you are being offered the opportunity to enroll in health coverage offered by The City of Miami Beach. You have the right to decline or waive coverage. If you do waive coverage for yourself, you may not cover dependents under the City of Miami Beach health plan.

Note that if you waive coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

The decision to waive coverage has these consequences for you:

- If you waive this coverage and do not obtain coverage on your own, you will be subject to a penalty under the individual responsibility requirement of the ACA.
- If you waive coverage, you cannot enroll in The City of Miami Beach's health plan until the next open enrollment, unless you experience a qualified change in status. Examples include if you are covered under another plan but that coverage is lost, or if you gain a new dependent through birth, adoption, or marriage. However, you must request to enroll in your plan within 30 days of the qualified change in status. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the City of Miami Beach has offered me affordable minimum essential coverage, as defined under the ACA, for the period from October 1, 2017 - September 30, 2018. I have read the above and I understand the consequences of waiving coverage.

Dental - Not applicable to Fire Employees

Coverage Type ☐ Cigna DHMO ☐ Cigna DPPO ☐ No Coverage

DHMO Office # _____

Coverage Level ☐ Employee Only ☐ Employee +1 ☐ Family

Life Insurance

Basic Life Insurance is mandatory. The City of Miami Beach pays 50% of this premium. You may elect Supplemental Life Insurance from 1 time to 5 times your annual pay. In addition, you may also elect life insurance for your spouse and/or your dependent children. Your combined Basic and Supplemental Life elections may not exceed a coverage amount of $500,000.

Basic Life Insurance - You are automatically enrolled in Basic Life Insurance.

Supplemental Life Insurance - You may elect 1 time to 5 times your annual pay.

☐ 1x Annual Pay ☐ 2x Annual Pay ☐ 3x Annual Pay ☐ 4x Annual Pay ☐ 5x Annual Pay

Dependent Life Insurance - You may elect coverage for your spouse and dependent children. Your coverage election cannot be greater than 50% of your Supplemental Life election.

☐ $20,000 spouse/$10,000 child(ren) ☐ $30,000 spouse/$10,000 child(ren)

☐ $40,000 spouse/$10,000 child(ren) ☐ $50,000 spouse/$10,000 child(ren)

Disability Insurance

You may elect Short-Term Disability and/or Long-Term Disability coverage. Your coverage and premium are based on your annual pay.

☐ **Short-Term Disability** - Replaces 60% of your weekly pay

☐ **Long-Term Disability** - Replaces 60% of your monthly pay

Flexible Spending Account (FSA)

You may elect to contribute to the Medical FSA and/or the Dependent Care FSA. The annual contribution limit for the Medical FSA is $2,600 and $5,000 for the Dependent Care FSA. This plan is effective October 1, 2017.

Election ☐ Medical FSA ☐ Dependent Care FSA ☐ No Coverage

Annual Contribution $ _____ $ _____

Bi-Weekly Payroll Deduction $ _____ $ _____

Health Savings Account (FSA)

Participation in the HSA is limited to those employees who elect the High Deductible Health Plan (HDHP). You may elect to contribute to the Health Savings Account. Please refer to the open enrollment benefit summary for contribution limits and the City's employer contribution.

Election ☐ HSA ☐ No Coverage

Annual Contribution $ _____

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 ☐ Dependent Life Insurance

Last Name | First Name | MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Date of Birth (MMDDYYYY) ☐☐ / ☐☐ / ☐☐☐☐

Relationship: ☐ Spouse ☐ Child ☐ Other

Gender ☐ Female ☐ Male _____

_____
DHMO Office Number (DHMO plan only) Current Patient? ☐ Yes ☐ No

2. 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 _____

_____
DHMO Office Number (DHMO plan only) Current Patient? ☐ Yes ☐ No

3. 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 _____

_____
DHMO Office Number (DHMO plan only) Current Patient? ☐ Yes ☐ No

4. 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 _____

_____
DHMO Office Number (DHMO plan only) Current Patient? ☐ Yes ☐ No

5. 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 _____

_____

DHMO Office Number (DHMO plan only) Current Patient? ☐ Yes ☐ No

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 pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected. The amount of my required bi-weekly contributions for each benefit option I have elected has been provided to me by the Human Resources Department. 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 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. 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 also 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.
- 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 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 any 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.
- The City of Miami Beach is having an active enrollment process for the upcoming plan year which begins on October 1, 2017. This means that during open enrollment (August 14th through September 1st), all benefit-eligible employees must respond by making elections via the Employee Self Service link or on this enrollment form in order to accept, continue, confirm, change, decline or waive any coverage.

Signature

Employee Signature	**Date**