MIAMIBEACH

City of Miami Beach Group Health
2017/18 Benefits Change Form
General Retirees

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

☐ 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 date Month: _____ Day: _____ Year: 20_____

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

Date of Qualifying Life Event (MM/DD/YYYY) Month: _____ Day: _____ Year: 20_____

Medical - Does not apply to Police and Fire Employees.

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 - Does not apply to Fire Employees

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 ☐ Add ☐ Change ☐ Delete

☐ 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 ☐ Add ☐ Change ☐ Delete

☐ 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 ☐ Add ☐ Change ☐ Delete

☐ 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 ☐ Add ☐ Change ☐ Delete

☐ 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 ☐ Add ☐ Change ☐ Delete

☐ 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_____

Prior Coverage

This section must be completed if this is your first enrollment in the City of Miami Beach Group Health Plan.

Within the past 18 months, have you had any individual or other group medical and/or dental coverage including Medicare?

Medical ☐ Yes ☐ No

If yes, please provide a copy of your Certificate of Prior Coverage from your plan.

Dental ☐ Yes ☐ No

If yes, please provide a copy of your Certificate of Prior Coverage from your plan.

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.
- Upon becoming a benefit-eligible employee, I understand that I must complete this enrollment form in order to accept, confirm, change, decline or waive any coverage.

Signature

Employee Signature	**Date**

Important

If you wish to enroll in any of the City's Supplemental Benefit Options, your enrollment must be completed within 30 days of your date of hire. Enrollment requests received after this deadline cannot be accepted. Your enrollment opportunity will be during the City's Annual Open Enrollment process which occurs between August and September of each year with a coverage effective date of October 1 of the same year.