MIAMIBEACH

2022/23 Annual Open Enrollment Change Form
General Retirees

Coverage Effective Date:

October 1, 2022

This form is due by Wednesday, August 31, 2022 IF CHANGES ARE BEING MADE

General Information

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ | 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 - Does not apply to retirees enrolled in the FOP or IAFF Health Trust plan.

No new enrollees may enroll in the PPO as of October 1, 2019.

Carrier ☐ Cigna ☐ No Coverage

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

Coverage Level ☐ Retiree Only ☐ Retiree +1 ☐ Family

Dental - Does not apply to retirees enrolled in the IAFF Health Trust plan.

Coverage Type ☐ Cigna DHMO ☐ Cigna DPPO ☐ No Coverage

DHMO Office # _____

Coverage Level ☐ Retiree Only ☐ Retiree +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

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

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

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

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 # _____ 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.
- 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**