MIAMIBEACH

City of Miami Beach Group Health
2023/2024 Benefits Enrollment
IAFF Employees

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 | Hire Date or Full-Time Appointment Date __ / __ / ____ (MM/DD/YYYY)

Life Insurance

Basic Life Insurance is mandatory. The City of Miami Beach pays 50% of this premium. You may elect Supplemental Life in increments of $10,000. Your Supplemental Life election is limited to 5 times your annual base pay. The guaranteed issue amount is $300,000. Evidence of insurability will be required if applying for any amount over $300,000. 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 – Your election is limited to 5 times your annual pay. Coverage amount must be requested in increments of $10,000. You are responsible for the entire premium which is deducted from your paycheck after taxes.

Coverage Amount _____ ☐ No Coverage

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.

☐ No Coverage

☐ $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 ☐ No Coverage

☐ **Long-Term Disability** - Replaces 60% of your monthly pay ☐ No Coverage

Flexible Spending Account (FSA)

You may elect to contribute to the Medical FSA and/or the Dependent Care FSA. Please refer to the benefit summary for contribution limits. This enrollment is valid through the end of the current plan year.

Election	☐ Medical FSA	☐ Dependent Care FSA	☐ No Coverage
Annual Contribution	$ _____	$ _____	
Bi-Weekly Payroll Deduction	$ _____	$ _____	

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

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 health and dental plan premium contributions are reduced 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 **45 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 benefit options, your enrollment must be completed within 45 days of your date of hire. Your next 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.