SPECIAL RISK RETIREE HEALTH INSURANCE SUPPLEMENT
For designated bargaining unit employees represented by the Dade County Police Benevolent Association and the Dade County Association of Firefighters Local 1403

NAME: _____ EMPLOYEE ID#: _____

ADDRESS: _____ DATE OF BIRTH: _____

_____ HOME TELEPHONE: _____

_____ WORK TELEPHONE: _____

STATUS: _____

DEPT: _____

CLASSIFICATION: _____

PROGRAM ELECTION

I ELECT TO RECEIVE THE CASH SUPPLEMENT OF $150.00 per month

MY RETIREMENT DATE WILL BE: _____

(INITIALS)

I UNDERSTANDTHAT IT IS MY RESPONSIBILITY TO COMPLETE A HEALTH INSURANCE APPLICATION FROM MIAMI-DADE COUNTY'S BENEFITS ADMINISTRATION UNIT OR AN APPLICATION FOR THE UNION PLAN IF I CHOOSE TO REMAIN IN A COUNTY SPONSORED OR UNION-SPONSORED INSURANCE PLAN…… _____

I UNDERSTAND THAT I SHALL BE RESPONSIBLE FOR PAYING SOCIAL SECURITY TAXES AND WITHHOLDING, WHERE APPLICABLE (A W2 Form will be issued annually)……..... _____

I UNDERSTAND THAT THE CASH SUPPLEMENT WILL END IN 10 YEARS, OR AT AGE OF 65, WHICHEVER IS EARLIER……..... _____

I UNDERSTAND THAT THERE ARE NO SURVIVOR BENEFITS IF I AM DECEASED PRIOR TO RECEIVING THE FULL BENEFIT PERIOD…….. _____

I CERTIFY THAT I HAVE AT LEAST 25 YEARS OF SPECIAL RISK FLORIDA RETIREMENT SYSTEM (FRS) COUNTY SERVICE OR 30 YEARS OF REGULAR CLASS FRS COUNTY SERVICE AND SATISFY THE ELIGIBILITY CRITERIA…… _____

IF YOU HAVE ANY QUESTIONS CALL (305) 375-5633

PLEASE RETURN APPLICATION TO:
Miami-Dade County
Benefits Administration Unit
111 NW 1st Street, Suite 2340
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368

_____ _____

SIGNATURE DATE

BENEFITS ADMINISTRATION UNIT

Effective Date:

Authorized By: Check if address changed: _____