2024 NEW RETIREE INSURANCE BENEFITS ELECTION FORM

*For **Retirees Over Age 65 and/or Medicare Eligible***

This form must be received by the Benefits Administration Unit no later than thirty (30) days following your retirement date, otherwise you forfeit Retiree Group coverage.

Name: _____ Emp. ID: _____ Date of Retirement: _____
Address: _____City, State & Zip Code: _____
Date of Birth: _____ Phone: _____ E-Mail Address: _____

MEDICAL COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates (Must be enrolled in Medicare Parts A and B to be eligible for any of the AvMed over 65 plans)	**AvMed High With RX**	**AvMed High W/O RX**	**AvMed Medicare National Choice**	**AvMed Medicare Advantage Plan**
Retiree Over 65 Only	☐ $ 760.55	☐ $ 330.59	☐ $ 377.08	☐ $ 0.00
Retiree Over 65 & Spouse/Domestic Partner Over 65	☐ $1,442.96	☐ $ 627.23	☐ $ 754.16	☐ $ 0.00
Retiree over 65 & Spouse/Domestic Partner Under 65 on Avmed High Opt HMO	☐ $1,521.90	☐ $1,091.94	☐ $1,138.43	☐ $ 761.35
Retiree over 65 & Children on AvMed High Opt HMO	☐ $1,542.89	☐ $1,112.93	☐ $1,159.42	☐ $ 782.34
Retiree Over 65 & Spouse/Domestic Partner Over 65, Child(ren) on AvMed POS Plan	☐ $2,865.75		☐ $2,176.96	
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO	☐ $2,063.12		☐ $1,679.65	☐ $1,302.57
Retiree Over 65 & Spouse/Domestic Partner Under 65 on AvMed Select Network HMO*	☐ $1,452.84	☐ $1,022.87	☐ $1,069.37	☐ $ 692.29
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed Select Network HMO*	☐ $1,955.50	☐ $1, 525.54	☐ $1,572.03	☐ $1,194.95
Retiree Over 65 & Spouse/Domestic Partner Over 65, Child(ren) over 26 on AvMed High Opt. HMO	☐ $2,225.30	☐ $1,409.57	☐ $1,536.50	☐ $ 782.34
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan	☐ $3,193.89		☐ $2,810.43	☐ $2,433.35

**AvMed Plans not available outside Miami-Dade, Broward & Palm Beach Counties - **Medicare Advantage options include dental and vision coverage.*

DENTAL COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates	**Delta Dental PPO℠**		**DeltaCare® DHMO**	
	Standard	*Enriched*	*Standard*	*Enriched*
Retiree Only	☐ $ 27.53	☐ $ 38.78	☐ $ 9.93	☐ $ 11.18
Retiree & one dependent	☐ $ 54.52	☐ $ 76.71	☐ $ 16.43	☐ $ 18.53
Retiree & dependents	☐ $ 87.90	☐ $123.74	☐ $ 25.18	☐ $ 29.47

VISION COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates for:	**Humana Vision Program**	
	Standard	*Enriched*
Retiree Only	☐ $ 7.36	☐ $ 9.08
Retiree & one dependent	☐ $ 14.72	☐ $18.15
Retiree & dependents	☐ $ 26.44	☐ $33.38

If medical, dental and/or vision coverage for dependent(s) is selected, please provide the information below.

Name	**Relationship****	**SSN**	**DOB**	**M/F**	**Indicate Coverage Selected**
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision
					☐ Medical ☐ Dental ☐ Vision

***SP- Spouse, CH-Child, DP-Domestic Partner, DPCH- Child of Domestic Partner*

LIFE INSURANCE COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Life Insurance Benefit	**Monthly Rates**		
	Age 65-69	**Age 70-74**	**Age 75+**
$15,000	☐ $ 11.03	☐ $ 18.20	☐ $ 25.16
$20,000	☐ $ 14.70	☐ $ 24.26	☐ $ 33.54

To update your life insurance beneficiary designation, visit **LifeBenefits.com**

_____ Initials

I am aware that it is my responsibility to read and understand the contents of the Retiree Insurance Benefits Handbook available at https://www.miamidade.gov/global/humanresources/benefits/retiree-insurance-faqs.page

Signature _____ **Date** _____

FOR OFFICE USE ONLY

Status: _____ Ret. Kind: _____ Ret. Type:
Longevity: FRS _____ County _____ Other Remarks: _____

Please sign, date, and mail or fax this form to:
Miami-Dade County – Human Resources
Benefits Administration Unit
111 NW 1st Street, Suite 2324
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368