2025 New Retiree Insurance Benefits Election Form

For Retirees Over Age 65

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	AvMed High With RX	AvMed High W/ O RX
Retiree Over 65 Only	☐ $760.55	☐ $330.59
Retiree Over 65 & Spouse/Domestic Partner Over 65	☐ $1,442.96	☐ $627.23
Retiree over 65 & Spouse/Domestic Partner Under 65 on Avmed High Opt HMO	☐ $1,627.69	☐ $1,197.73
Retiree over 65 & Children on AvMed High Opt HMO	☐ $1,651.50	☐ $1,212.91
Retiree Over 65 & Spouse/Domestic Partner Over 65, Child(ren) on AvMed POS Plan	☐ $3,063.46	
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO	☐ $2,244.11	
Retiree Over 65 & Spouse/Domestic Partner Under 65 on AvMed Select Network HMO*	☐ $1,549.03	☐ $1,119.07
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed Select Network HMO*	☐ $2,121.55	☐ $1, 691.59
Retiree Over 65 & Spouse/Domestic Partner Over 65, Child(ren) over 26 on AvMed High Opt. HMO	☐ $2,334.01	☐ $1,518.28
Retiree Over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan	☐ $3,531.99	

*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	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

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

_____ 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.

Initial

_____ _____

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 Division
111 NW 1st Street, Suite 2324
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-136