2025 New Retiree Insurance Benefits Election Form

For Retirees Under 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 POS	AvMed High Opt HMO	AvMed MDC Select Network HMO*	AvMed MDC Jackson First HMO*
Retiree Under 65	☐ $1,948.69	☐ $867.14	☐ $788.48	☐ $631.79
Retiree Under 65 & Spouse/Domestic Partner Under 65	☐ $3,754.72	☐ $1,905.83	☐ $1,740.86	☐ $1,412.01
Retiree Under 65 & Child(ren)	☐ $3,569.19	☐ $1,758.19	☐ $1,605.31	☐ $1,300.72
Retiree Under 65 & Spouse/Domestic Partner Under 65, plus Child(ren)	☐ $4,720.13	☐ $2,350.70	☐ $2,149.48	☐ $1,748.40
Retiree Under 65 & Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High With RX**		☐ $1,627.69	☐ $1,549.03	
Retiree Under 65 & Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High W/O RX **		☐ $1,197.73		
Retiree Under 65 & Children, Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High With RX**	☐ $3,531.99	☐ $2,244.11	☐ $2,121.55	
Retiree Under 65 & Children, Spouse/Domestic Partner Over 65 and/or Medicare Eligible on AvMed High W/O RX**				

*AvMed Plans not available outside Miami-Dade, Broward & Palm Beach Counties **Must be enrolled in Medicare Parts A and B to be eligible for any of the AvMed over 65 plans

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	☐ $26.44	☐ $18.15
Retiree & dependents	☐ $25.18	☐ $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

The value of the Miami-Dade County Retiree Group Life Insurance Policy is one-time your base annual salary at the time of retirement. The 2024 rate is 15.8 cents per thousand dollars per month. To update your life insurance beneficiary designation, visit LifeBenefits.com.

_____ 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