

MIAMI BEACH

City of Miami Beach Group Health Enrollment Form FOP Health Trust Participants

For Benefit Office use only

Grp #: Dental _____

Ben #: _____

Class/Division _____

General Information

Last Name

First Name

MI

Social Security Number

City ID

Date of Birth (MM/DD/YYYY)

Gender

Daytime Phone

Evening Phone

Street Address

Apt/Suite/PO Box Number

City

State

Zip Code

Employment Status: I am an Active Employee I am a Retiree

Dental Plan – Please elect your coverage type and coverage level.

Coverage Type: MetLife DHMO MetLife PDP No Coverage

Coverage Level: Employee Only Employee + 1 Family

Employee Primary Dentist (MetLife DHMO plan only)

Dentist ID #

Are you a current patient? Yes No

Life Insurance –You may elect Supplemental Life Insurance from 1 to 5 times your annual pay. In addition, you may also elect life insurance for your spouse and/or your dependent children. Supplemental Life Insurance requests in excess of \$250,000 may be subject to insurance carrier approval. Your Dependent Life Insurance election cannot be more than fifty percent (50%) of the employee's Supplemental Life Insurance election.

Supplemental Life Insurance - You may elect 1 times to 5 times your annual pay.

1x Annual Pay 2x Annual Pay 3x Annual Pay

4x Annual Pay 5x Annual Pay No Coverage

Dependent Life Insurance - You may elect coverage for your spouse and dependent children.

\$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)

No Coverage

4. Plan Dental Dependent Life Insurance

Last Name

[Grid for Last Name]

First Name

[Grid for First Name]

MI

[MI Input Box]

Social Security Number

[Grid for Social Security Number]

Date of Birth (MMDDYYYY)

[Grid for Date of Birth]

Relationship:

Spouse Child Other

Gender Female Male

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes No

Primary Dentist (MetLife DHMO plan only)

Provider ID#

5. Plan Dental Dependent Life Insurance

Last Name

[Grid for Last Name]

First Name

[Grid for First Name]

MI

[MI Input Box]

Social Security Number

[Grid for Social Security Number]

Date of Birth (MMDDYYYY)

[Grid for Date of Birth]

Relationship:

Spouse Child Other

Gender Female Male

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes No

Primary Dentist (MetLife DHMO plan only)

Provider ID#

Prior Coverage This section must be completed if this is your first enrollment in the City of Miami Beach Group Health Plan.

Within the past 18 months, have you had any individual or other group dental coverage?

Dental Yes No

If yes, please provide copy of your Certificate of Prior Coverage from your plan.

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 Human Resources. I also understand the following:

- My premium contributions are taken 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 **30 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.
- During the Annual Open Enrollment each year I will be provided the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return an election form during that time, I will be treated as having elected to continue the benefit coverage then in effect and the associated required contributions, unless otherwise required by the City.
- 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.

Signature

Employee Signature

Date