PALM BEACH COUNTY FireFighters
EMPLOYEE BENEFITS FUND

VOLUNTARY ELECTION TO REJECT MEDICAL AND DENTAL PLAN COVERAGE

Last Name	First Name	M.I.	Social Security #

Address	City	State	Zip

Telephone Number	Cell Number	E Mail

Election to Reject Coverage*

CIRCLE (a) or (b)

(a) I HEREBY VOLUNTARILY REJECT COVERAGE under the Palm Beach County Firefighters Employee Benefits Fund for myself and any dependents in accordance with Section 112.11, Florida Statutes, which provides that participation in such group insurance shall be voluntary and that an employee may withdraw from such group insurance upon giving written notice thereof.

I understand that I and my dependents may not enroll any medical plan and dental plan offered by the Palm Beach County Firefighters Employee Benefits Fund After December 31, 2015.

_____ _____
Employee Signature Date Signed

OR

(b) I HEREBY VOLUNTARILY REJECT COVERAGE under the Palm Beach County Firefighters Employee Benefits Fund for myself and/or my dependents because I and/or my dependents have coverage under another group health plan.

I understand since I am declining enrollment for myself and/or my dependents, including my spouse, because of other health insurance coverage, I may not enroll any medical plan and dental plan offered by the Palm Beach County Firefighters Employee Benefits Fund After December 31, 2015.

*** Rejection of any medical, dental, or vision benefits still does not eliminate automatic participation in the life insurance benefit.**

_____ _____
Employee Signature Date Signed

Fund Use Only: _____ _____ _____
Signature Title Date

PROVIDING QUALITY BENEFITS FOR YOU AND YOUR FAMILY

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