PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND
VOLUNTARY ELECTION TO REJECT MEDICAL AND DENTAL PLAN COVERAGE

Last Name	First Name	M.I.	Social Security No.

Date of Birth	Number of Dependents

Work Location	Telephone Number

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Election to Reject Coverage*
Select (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 enroll or re-enroll in any medical plan and dental plan offered by the Palm Beach County Firefighters Employee Benefits Fund subject to the pre-existing condition exclusion provisions during the annual Open Enrollment.

_____ _____
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 in the future be able to enroll myself and/or my dependents in this Plan, provided I request enrollment within thirty (30) days after my other coverage ends.

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

_____ _____
Employee Signature Date Signed

Witnessed by: _____ _____ _____
Signature Title Date