PALM BEACH COUNTY FIREFIGHTERS
EMPLOYEE BENEFITS FUND

BENEFIT PLAN ELECTION FORM

First Name	Last Name	SSN

Email	Phone Number
Address	PO Box
City	State	Zip
Gender	Date of Birth

BENEFIT PLAN ELECTIONS

EMPLOYEE SUPPLEMENTAL LIFE

Check One Option:

Benefit Minimum	$10,000	☐
Benefit Guarantee*	$120,000	☐
Benefit Maximum	$500,000	☐
Other**: ($10,000 – $500,000 in increments of $10,000)	Amount _____	☐
Decline Coverage		☐

Benefit Minimum: $10,000
Benefit Maximum: $500,000

*Late entrants and increases to amount over guaranteed issue limit of $120,000 require evidence of insurability.

**If other is selected, benefit amount in increment of $10,000 must be provided.

SPOUSE SUPPLEMENTAL LIFE

Covered Individual:

First Name	Last Name	Relationship	SSN	Gender	Date of Birth

Check One Option (not to exceed employee amount):

Benefit Minimum	$10,000	☐
Benefit Guarantee*	$50,000	☐
Benefit Maximum	$500,000	☐
Other**: ($10,000 – $500,000 in increments of $10,000)	Amount _____	☐
Decline Coverage		☐

Benefit Minimum: $10,000
Benefit Maximum: $500,000 (not to exceed employee amount)

*Late entrants and increases to amount over guaranteed issue limit of $50,000 require evidence of insurability.

**If other is selected, benefit amount in increment of $10,000 must be provided.

CHILD SUPPLEMENTAL LIFE

Check One Option (not to exceed employee amount):

Benefit Minimum*	$2,500	☐
Benefit Maximum*	$10,000	☐
Other**: ($2,500 – $10,000 in increments of $2,500)	Amount _____	☐
Decline Coverage		☐

Covered Dependents:

First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth

Benefit Minimum: $2,500

Benefit Maximum: $10,000 (increments of $2,500; not to exceed employee amount)

*Benefit ineligible until attaining 14 days of age. Benefit for individuals 14 days to 6 months, $1,000 paid benefit until attained age of 6 months. At 6 months, full benefit election amount will be paid in event of death.

**If other is selected, benefit amount in increment of $2,500 must be provided.

ACCIDENT PROTECTION PLAN

Tier	Rate per Month	Please Check One
Employee Only	$6.82	☐
Employee & Spouse	$10.89	☐
Employee & Children	$14.80	☐
Employee & Spouse & Children	$22.47	☐
Decline Coverage		☐

Covered Dependents:

First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth

HOSPITAL INDEMNITY PROTECTION PLAN

Tier	Rate per Month	Please Check One
Employee Only	$9.38	☐
Employee & Spouse	$20.59	☐
Employee & Children	$14.69	☐
Employee & Spouse & Children	$27.09	☐
Decline Coverage		☐

Covered Dependents:

First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth

CRITICAL ILLNESS PLAN

Covered Benefit $5,000 per covered individual

Tier	Please Check One
Employee Only	☐
Employee & Spouse	☐
Employee & Children	☐
Employee & Spouse & Children	☐
Decline Coverage	☐

Covered Dependents:

First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth
First Name	Last Name	Relationship	SSN	Gender	Date of Birth

Please return completed form to:

Mail: UHC Direct Billing Administration
PO Box 30616
Salt Lake City, UT 84130-0616

Fax: (855) 256-5640
Email: DirectBillAdministration@uhc.com

For plan benefit details, please visit: https://www.myffbenefits.com or call (800)444-5854.

Welcome to UHC Direct Billing Administration

Effective January 1, 2026, United Healthcare will be administering the monthly premium billing for your Palm Beach County Firefighters plans. These plans include Employee Supplemental Life, Dependent Supplemental Life, Accident Protection Plan, Critical Illness Protection Plan, and Hospital Indemnity Protection Plan.

If you choose to enroll, in December you will receive a welcome letter that details your plan information, premium amount and premium due date. Additionally you will receive information on how to access the billing portal. Your monthly invoice will be sent in a separate envelope.

•You have multiple payment options avilable within the billing portal. ACH draws and recurring credit card payments take place on the 5th business day of each month, but could take a few days to show on your bank statement. This scheduled date is reserved for you, giving you peace of mind and will help you track your payments.

•You can also pay by check or money order.

•Dedicated and skilled customer service representatives are available Monday-Friday, 7am to 5pm CT, to assist with managing your account.

More Questions?

Email:
DirectBillAdministration@uhc.com

Contact Information

Correspondence Address:
UHC
PO Box 30616
Salt Lake City, UT 84130-0616

Payment Address:
UHC
PO Box 2677
Omaha, NE 68103

UnitedHealthcare®