PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

2027 RETIREE-BENEFITS STATUS CHANGE FORM

This form is to be used for changes to benefit elections. Please complete ALL of the participant information and check the appropriate boxes to your choices. This form must be signed by the Participant.

PARTICIPANT INFORMATION: (Please Print – ALL blanks must be completed) UMR ID# _____

Participant Last Name _____ First Name _____ MI _____

Male _____ Female _____ Date of Birth _____ Email Address _____

Cell Phone # _____ Spouse Cell # _____ Spouse Email Address _____

Mailing Address (if changed) _____

ADD DEPENDENT(S) **Medical** **Dental** **Both**

First Name	Last Name	MI	Dependent's SS#	Relationship	Date of Birth (mm/dd/yyyy)
				SPOUSE SON DTR OTHER	
				SPOUSE SON DTR OTHER	
				SPOUSE SON DTR OTHER	

TERMINATE DEPENDENT(S) **Medical** **Dental** **Both**

First Name	Last Name	MI	Dependent's SS#	Relationship	Date of Birth (mm/dd/yyyy)
				SPOUSE SON DTR OTHER	
				SPOUSE SON DTR OTHER	

TERMINATE COVERAGE'S FOR PARTICIPANT & ALL DEPENDENT(S) **ALL COVERAGE** **MEDICAL** **DENTAL**

NAME CHANGE: Old Name: _____ New Name: _____

MEDICAL	w/ 0 Medicare	w/ 1 Medicare	w/ 2 Medicare
Please Initial desired Coverage		(Rates Monthly)	
Retiree Only	$1,100 _____	$897 _____	
Retiree +1	$1,585 _____	$1,382 _____	$1,179 _____
Retiree +2	$1,678 _____	$1,475 _____	$1,272 _____
Retiree +3	$1,775 _____	$1,572 _____	$1,369 _____
$33 for each dependent over 3:	_____ X $33 = _____ +	$1,775 = _____	

DENTAL	PPO HIGH	PPO LOW	HMO
Retiree Only	$63.77 _____	$53.03 _____	$13.33 _____
Retiree+Spouse	$134.29 _____	$111.67 _____	$23.30 _____
Retiree+Children	$168.32 _____	$139.97 _____	$28.86 _____
Retiree+Family	$225.21 _____	$187.27 _____	$36.62 _____

Over Age Dependents (26–30yrs) additional $400.00 per Month. Subtract OAD from head count and then add at the OAD rate
For example Retiree + 2 one is OAD: Retiree +1 rate $1,585 + OAD rate $400; Monthly Premium = $1,985
Above rate less # of OADS = $_____ + # of OAD _____ X $400 = $_____ = Monthly Premium $_____

INDICATE THE TYPE OF VISION COVERAGE YOU DESIRE:

Humana Vison Plan 1 - Single $5.37 per Month _____ Humana Vision Plan 2- No Additional cost _____
Family $15.36 per Month _____

I consent to changes of premiums that may occur from time to time as deemed necessary by the Board of Trustees.
All information provided is true, accurate, and complete to the best of my knowledge.

PARTICIPANTS SIGNATURE *X* _____ **DATE:** ____/____/____

Benefit Fund Use Only (Do Not Write In This Area)

FREQUENCY: MONTHLY STARTING _____/_____ EFFECTIVE DATE OF ACTION _____/_____/_____

QE _____ **X** _____ ____/__/____

BENEFITS FUND AUTHORIZING SIGNATURE **DATE**

REVIEWED _____

PBCFF EMPLOYEE BENFITS FUND – GRP # 76-410382

Send Completed Form To:

Benefits Administrator
PBC Firefighters Employee Benefits Fund
PO Box 20509 West Palm Beach, FL 33416-0509

Telephone: (561) 969-6663
Fax: (561) 727-3709
Email to: info@myffbenefits.com