

PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND
2021 ACTIVE EMPLOYEES-BENEFITS STATUS/SALARY 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
Date of Birth	County ID#	Email Address:
Cell Phone#	Spouse's Cell#	Spouses Email Address:
Mailing Address (if changed)		

ADD DEPENDENT(S)			Medical	Dental	Both	Date of Birth (mm/dd/yyyy)
First Name	Last Name	MI	Dependent's SS#	Relationship SPOUSE SON DTR OTHER		
				SPOUSE SON DTR OTHER		
				SPOUSE SON DTR OTHER		
				SPOUSE SON DTR OTHER		

TERMINATE DEPENDENT(S)			Medical	Dental	Both	Date of Birth (mm/dd/yyyy)
First Name	Last Name	MI	Dependent's SS#	Relationship SPOUSE SON DTR OTHER		
				SPOUSE SON DTR OTHER		
				SPOUSE SON DTR OTHER		
				SPOUSE SON DTR OTHER		

TERMINATE COVERAGE'S FOR PARTICIPANT & ALL DEPENDENT(S) CIRCLE ONE: ALL COVERAGE MEDICAL DENTAL

NAME CHANGE: OLD NAME: _____ New Name: _____

Please Initial Coverage Desired (Rates are Bi-Weekly)

	Medical	Dental	PPO HIGH	PPO LOW	HMO
Employee Only	\$92 _____	Employee Only	\$22.10 _____	\$21.05 _____	\$5.63 _____
Employee + 1	\$199 _____	Employee & Spouse	\$46.55 _____	\$44.33 _____	\$9.85 _____
Employee + 2	\$228 _____	Employee & Children	\$58.34 _____	\$55.56 _____	\$12.19 _____
Employee + 3	\$267 _____	Employee & Family	\$78.06 _____	\$74.34 _____	\$15.48 _____

Add \$10.00 for each Dependent over 3: _____ x \$10 = + \$267.00 = _____

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:** ____/____/____

Benefits Fund Use Only (Do Not Write In This Area)		
Frequency: _____ Bi-Weekly	Starting PPE ____/____/____	Effective Date Of Action ____/____/____
QE: _____	X _____	____/____/____
Reviewed: _____	BENEFITS FUND AUTHORIZING SIGNATURE PBCFF EMPLOYEE BENEFITS FUND GROUP # 76-410382	



Name: _____ Last 4 of Social: _____ Station: _____ Shift: _____

Coordination of Benefits (COB Form)

Dear Participant:

This policy requires us to determine if you and/or members of your family are covered by any other insurance plan other than Palm Beach County Firefighters Employee Benefits Fund. This is completed annually for each covered employee. Please complete this form and return to us ASAP.

Please circle the appropriate response (Yes or No) regardless of coverage.

Are you covered by: **Other Medical:** Y or N **Other Dental:** Y or N **Medicare:** Y or N
 Is your spouse covered by: **Other Medical:** Y or N **Other Dental:** Y or N **Medicare:** Y or N
 Are your dependents covered by: **Other Medical:** Y or N **Other Dental:** Y or N **Medicare:** Y or N

NOTE: Claims processing may be delayed pending your response.

NOTE: If at any point, after the date of this letter, you and/or your dependents coverage situation changes please contact our office @ 561-969-6663, so that we can obtain the proper information needed to properly coordinate benefits with the other carrier.

*** IMPORTANT ***

When Sending this form back please also include a copy of any other insurance carrier's ID card front and back (if any). Without this card we may be unable to verify eligibility and therefore be unable to coordinate benefits with your other carrier.

Policy Holder Signature: _____ Date: _____