# PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

## 2022 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 | |
| | | | | 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 are Monthly) | |
| Retiree Only | $740 _____ | $592 _____ | |
| Retiree +1 | $1,065 _____ | $917 _____ | $769 _____ |
| Retiree +2 | $1,128 _____ | | |
| Retiree +3 | $1,192 _____ | | |
| $23 for each dependent over 3:_____ | X $23 = _____ | + $1,192=_____ | |

| DENTAL | PPO HIGH | PPO LOW | HMO |
|---|---|---|---|
| Retiree Only | $47.89 _____ | $45.61 _____ | $12.20 _____ |
| Retiree+Spouse | $100.85 _____ | $96.05 _____ | $21.34 _____ |
| Retiree+Children | $126.41 _____ | $120.39 _____ | $26.42 _____ |
| Retiree+Family | $169.13 _____ | $161.08 _____ | $33.54 _____ |

**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**
7240 7th Place N
WPB, FL 33411

Telephone: (561) 969-6663
Fax: (561) 966-7760
Email to: info@myffbenefits.com

Form: rkr 9/2021

PALM BEACH COUNTY FireFighters EMPLOYEE BENEFITS FUND

Name: _____ Last 4 of Social: _____ RETIRED

# 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).

| | | | |
|---|---|---|---|
| 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 **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:** _____