PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

2025 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**

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) 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	$100 _____	Employee Only	$28.03 _____	$23.31 _____	$5.86 _____
Employee + 1	$223 _____	Employee & Spouse	$59.03 _____	$49.09 _____	$10.25 _____
Employee + 2	$255 _____	Employee & Children	$73.99 _____	$61.53 _____	$12.69 _____
Employee + 3	$301 _____	Employee & Family	$99.00 _____	$82.32 _____	$16.10 _____

Add $12.00 for each Dependent over +3 rate: _____ X $12 + $301.00 = _____

(OAD) Over Age Dependents Medical (26–30 yrs) additional $92.31. Subtract OAD from head count and then add dependent to OAD rate. For example: Employee + 1 with one OAD: Employee Only rate $100 + OAD rate $92.31; Bi-weekly deduction = $192.31

Employee + 2 with one OAD: Employee +1 rate $223 + OAD rate $92.31; Bi-weekly deduction = $315.31

Above rate less # of OADs = $_____ + # of OAD _____ X $92.31 = $_____ = Bi-Weekly Premium $_____

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

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

PALM BEACH COUNTY FireFighters EMPLOYEE BENEFITS FUND

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).

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:** _____