PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

2025 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		(ratesareMonthly)	
Retiree Only	$971 _____	$797 _____	
Retiree +1	$1,399 _____	$1,225 _____	$1,051 _____
Retiree +2	$1,481 _____		
Retiree +3	$1,566 _____		
$29 for each dependent over 3:	_____ X $29 = _____	+ $1,566 = _____	

DENTAL	PPO HIGH	PPO LOW	HMO
Retiree Only	$60.73 _____	$50.50 _____	$12.69 _____
Retiree+Spouse	$127.89 _____	$106.35 _____	$22.19 _____
Retiree+Children	$160.30 _____	$133.30 _____	$27.48 _____
Retiree+Family	$214.48 _____	$178.35 _____	$34.88 _____

Over Age Dependents (OAD 26–30yrs) additional $200.00 per Month. Subtract OAD from head count and then add the dependent to OAD rate. For example Retiree + 2 with one OAD: Retiree +1 rate $1,399 + OAD rate $200; Monthly Premium = $1,599
Above rate less # of OADS = $_____ + # of OAD _____ X $200 = $_____ = Monthly 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:** ____/____/____

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

Form: rkr 9/2024

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:** _____