## PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

## **2026 RETIREE-BENEFITS STATUS CHANGE FORM**

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

First Name Last Name MI Dependent's SS# Relationship (mm/dd/y, SPOUSE SON DTR OTHER DEPENDENT(S) Medical Dental Both	Participant Last NameFirst Name					MI
Mailing Address (if changed)    ADD DEPENDENT(S)   Medical   Dental   Both	MaleFemaleDa	ate of Birth	_Email Addr	ess		
ADD DEPENDENT(S)    First Name   Last Name   MI   Dependent's SSS   Relationship   Control of the (minds/s)	Cell Phone #	Spouse Cell #		Spouse Email Ado	dress	
ADD DEPENDENT(S)   Medical   Dental   Both	Mailing Address (if changed)	)				
First Name Last Name MI Dependent's SS# Relationship (mm/dd/y)  SPOUSE SON DTR OTHER SON DTR OTHER SPOUSE SON DTR OTHER SPOUSE SON DTR OTHER OTHER SON DTR OTHER SON DTR OTHER SON DTR OTHER SON DTR OTHER SO						
TERMINATE DEPENDENT(S)  Medical  Dental  Both    Dependent's SS#   Relationship   Control of the Company   Control of the Control of the Company   Control of the	First Name	Last Name	MI	Dependent's SS#	·	Date of Birth (mm/dd/yyyy
TERMINATE DEPENDENT(\$)    Medical   Dental   Both						
First Name  Last Name  MI  Dependent's SS#  Relationship  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:  DICAL w/0 Medicare w/1 Medicare w/2 Medicare  Retiree Only \$60.73 \$50.50 \$12.69 exert \$1.539 \$1.354 \$1.169 Retiree+Spouse \$127.89 \$106.35 \$22.19 exert \$1.539 \$1.354 \$1.259 Retiree+Children \$160.30 \$133.30 \$27.48 exert \$1.723 \$1.538 \$1.353 Retiree+Family \$214.48 \$178.35 \$34.88 exert \$1.723 \$1.538 \$1.353 Retiree+Family \$214.48 \$178.35 \$34.88 exert \$1.723 \$1.538 \$1.533 Retiree + Tank \$1.539 + OAD rate \$400; Monthly Premium \$1.939 exert \$1.939 exert \$1.939 \$1.000					SPOUSE SON DTR OTHER	₹
CAL   W   O Medicare   W   1 Medicare   W   2 Medicare   DENTAL   PPO HIGH   PPO LOW   HMO	TERMINATE DEPENDEN	NT(s) M	ledical	Dental	Both	I
Name Change: Old Name:	First Name	Last Name	MI	Dependent's SS#		Date of Birtl (mm/dd/yyyg
Name Change: Old Name:					SPOUSE SON DTR OTHER	?
Retiree+Spouse \$127.89 \$106.35 \$22.19 \$1.444 \$1,259 \$1.444 \$1,259 \$1.444 \$1,259 \$1.444 \$1,259 \$1.444 \$1,259 \$1.444 \$1,259 \$1.448		w/ 1 Medicare w/ 2	Medicare			
see +1 \$1,539				DENTAL IIO	IIIGII ITOLOW	HMO
Retiree+Children \$160.30	ase Initial desired Coverage	e (Rates Monthly)		DENTAL 110	IIIGH ITOLOW	HWIO
se +3 \$1,723 \$1,538 \$1,353 Retiree+Family \$214.48 \$178.35 \$34.88	ee Only \$1,068	\$883		Retiree Only \$60	).73 \$50.50	\$12.69
or each dependent over 3: X \$32 = + \$1,723 =	ee Only \$1,068 ee +1 \$1,539	\$883 \$1,354 \$1,16		Retiree Only \$60 Retiree+Spouse \$12	0.73	\$12.69 \$22.19
example Retiree + 2 one is OAD: Retiree +1 rate \$1,539 + OAD rate \$400; Monthly Premium = \$1,939  ove rate less # of OADS = \$	te Only \$1,068 te +1 \$1,539 te +2 \$1,629	\$883 \$1,354\$1,16 \$1,444\$1,25	9	Retiree Only \$60 Retiree+Spouse \$12 Retiree+Children \$16	0.73 \$50.50 0.7.89 \$106.35 50.30 \$133.30	\$12.69 \$22.19 \$27.48
INDICATE THE TYPE OF VISION COVERAGE YOU DESIRE:  dumana Vison Plan 1 - Single \$5.37 per Month Humana Vision Plan 2- No Additional cost  Family \$15.36 per Month  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)  EREQUENCY: MONTHLY STARTING / EFFECTIVE DATE OF ACTION /	te Only \$1,068 te +1 \$1,539 te +2 \$1,629 te +3 \$1,723	\$883 \$1,354 \$1,16 \$1,444 \$1,25 \$1,538 \$1,35	3	Retiree Only \$60 Retiree+Spouse \$12 Retiree+Children \$16 Retiree+Family \$21	0.73 \$50.50 0.7.89 \$106.35 50.30 \$133.30	\$12.69 \$22.19 \$27.48
Humana Vison Plan 1 - Single \$5.37 per Month Humana Vision Plan 2- No Additional cost Family \$15.36 per Month 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) EFFECTIVE DATE OF ACTION /	te Only \$1,068 te +1 \$1,539 te +2 \$1,629 te +3 \$1,723 tor each dependent over 3: ter Age Dependents (26–3	\$883 \$1,354 \$1,16 \$1,444 \$1,25 \$1,538 \$1,35 _X \$32 = + \$1,72 30yrs) additional \$400.00	9 3 23 = per Month.	Retiree Only \$60 Retiree+Spouse \$12 Retiree+Children \$16 Retiree+Family \$21  Subtract OAD from head	0.73 \$50.50 7.89 \$106.35 50.30 \$133.30 4.48 \$178.35	\$12.69 \$22.19 \$27.48 \$34.88
FREQUENCY: MONTHLY STARTING/ EFFECTIVE DATE OF ACTION/	ee Only \$1,068 ee +1 \$1,539 ee +2 \$1,629 ee +3 \$1,723 for each dependent over 3: er Age Dependents (26–3) example Retiree + 2 one	\$883 \$1,354 \$1,16 \$1,444 \$1,25 \$1,538 \$1,35 X \$32 = + \$1,72 30yrs) additional \$400.00 is OAD: Retiree +1 rate	9	Retiree Only \$60 Retiree+Spouse \$12 Retiree+Children \$16 Retiree+Family \$21  Subtract OAD from head OAD rate \$400; Monthly	0.73 \$50.50 7.89 \$106.35 50.30 \$133.30 4.48 \$178.35 I count and them add at the OA Premium = \$1,939	\$12.69 \$22.19 \$27.48 \$34.88
FREQUENCY: MONTHLY STARTING/ EFFECTIVE DATE OF ACTION//	ee Only \$1,068 ee +1 \$1,539 ee +2 \$1,629 ee +3 \$1,723 for each dependent over 3: er Age Dependents (26–3) example Retiree + 2 one ove rate less # of OADS =  Humana Vison Plan 1 - Sin Fa	\$883 \$1,354 \$1,16 \$1,444 \$1,25 \$1,538 \$1,35 \$1,35 \$1,35 \$1,72 30yrs) additional \$400.00 is OAD: Retiree +1 rate = \$ + # of 0 INDICATE THE angle \$5.37 per Month amily \$15.36 per Month miums that may occur from	99	Retiree Only \$60 Retiree+Spouse \$12 Retiree+Children \$16 Retiree+Family \$21  Subtract OAD from head OAD rate \$400; Monthly X \$400 = \$  ISION COVERAGE YOU D Humana Vision Pla  as deemed necessary by the	0.73 \$50.50 27.89 \$106.35 50.30 \$133.30 14.48 \$178.35 d count and them add at the OA Premium = \$1,939 = Monthly Premium \$ ESIRE: n 2- No Additional cost	\$12.69 \$22.19 \$27.48 \$34.88
	tee Only \$1,068 tee +1 \$1,539 tee +2 \$1,629 tee +3 \$1,723 tor each dependent over 3: ter Age Dependents (26–3 example Retiree + 2 one over rate less # of OADS = 1 to Consent to changes of prendiction provided is PARTICIPANTS SICE	\$883 \$1,354 \$1,16 \$1,444 \$1,25 \$1,538 + \$1,72 30yrs) additional \$400.00 is OAD: Retiree +1 rate \$\frac{1}{2} + \frac{1}{2} \text{O} \text{O} \text{O} \text{O} \text{INDICATE THE} Ingle \$5.37 per Month	9	Retiree Only \$60 Retiree+Spouse \$12 Retiree+Children \$16 Retiree+Family \$21  Subtract OAD from head OAD rate \$400; Monthly X \$400 = \$  SION COVERAGE YOU D Humana Vision Pla as deemed necessary by the of my knowledge.	\$50.50	\$12.69 \$22.19 \$27.48 \$34.88
QE X	the Only \$1,068 the +1 \$1,539 the +2 \$1,629 the +3 \$1,723 the e+3 \$1,723 the properties of the example Retiree + 2 one over rate less # of OADS = the order of the example Retiree + 2 one over rate less # of OADS = the example Retiree + 2 one over rate l	\$883 \$1,354 \$1,16 \$1,444 \$1,25 \$1,538 + \$1,72 30yrs) additional \$400.00 is OAD: Retiree +1 rate = \$ + # of 0 INDICATE THE and specified by the state of the state o	99	Retiree Only \$60 Retiree+Spouse \$12 Retiree+Children \$16 Retiree+Family \$21  Subtract OAD from head OAD rate \$400; Monthly X \$400 = \$  SION COVERAGE YOU D Humana Vision Pla as deemed necessary by the of my knowledge.	\$50.50	\$12.69 \$22.19 \$27.48 \$34.88 AD rate
	the Only \$1,068 the +1 \$1,539 the +2 \$1,629 the +3 \$1,723 to reach dependent over 3: the rage Dependents (26—3) the example Retiree + 2 one over rate less # of OADS =  Thumana Vison Plan 1 - Sin  Factorisent to changes of prematal information provided is  PARTICIPANTS SICE  Benefit Fund Use Only (Do Note of Street)  FREQUENCY: MONTHLY STA	\$883 \$1,354 \$1,16 \$1,444 \$1,25 \$1,538 \$1,35 X \$32 = + \$1,72 30yrs) additional \$400.00 is OAD: Retiree +1 rate = \$ + # of O INDICATE THE agle \$5.37 per Month amily \$15.36 per Month miums that may occur from true, accurate, and complet GNATURE X	per Month. \$\frac{1}{2}\$ =  per Month. \$\frac{1}{2}\$ =  PAD  TYPE OF VI  time to time to the best	Retiree Only \$66 Retiree+Spouse \$12 Retiree+Children \$16 Retiree+Family \$21  Subtract OAD from head OAD rate \$400; Monthly X \$400 = \$  ISION COVERAGE YOU D Humana Vision Pla as deemed necessary by the of my knowledge.	\$50.50	\$12.69 \$22.19 \$27.48 \$34.88 AD rate

**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