PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

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 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: _____

Please Initial Coverage Desired (Rates are Bi-Weekly)

	Medical		**Dental**	**HMO**		**PPO**	
Employee Only	($97.55)	____	Employee Only	($ 5.63)	———	($21.05)	———
Employee + 1	($195.10)	____	Employee & Spouse	($ 9.85)	———	($44.33)	———
Employee + 2	($223.18)	____	Employee & Child(ren)	($12.19)	———	($55.56)	———
Employee + 3 or More	($251.26)	____	Employee & Family	($15.48)	———	($74.34)	———

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: _____ Bi-Weekly starting PPE _____/_____/_____

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**

Revised 10/2016

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 have insurance coverage thru another carrier. This is done annually for each covered person. Please complete the following form and send back to us, **claims processing may be delayed pending your response.**

Policy Holder Coverage

Are you covered under any other insurance policy? **Medical: ❑Yes ❑ No Dental: ❑Yes ❑ No Medicare: ❑Yes ❑ No**

List all covered dependants, answer Yes or No for Other Insurance Carrier Coverage

Name:_____________________________ **Medical: ❑Yes ❑ No Dental: ❑Yes ❑ No Medicare: ❑Yes ❑ No**

Name:_____________________________ **Medical: ❑Yes ❑ No Dental: ❑Yes ❑ No Medicare: ❑Yes ❑ No**

Name:_____________________________ **Medical: ❑Yes ❑ No Dental: ❑Yes ❑ No Medicare: ❑Yes ❑ No**

Name:_____________________________ **Medical: ❑Yes ❑ No Dental: ❑Yes ❑ No Medicare: ❑Yes ❑ No**

Name:_____________________________ **Medical: ❑Yes ❑ No Dental: ❑Yes ❑ No Medicare: ❑Yes ❑ No**

Name:_____________________________ **Medical: ❑Yes ❑ No Dental: ❑Yes ❑ No Medicare: ❑Yes ❑ No**

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:** _______________