

PALM BEACH COUNTY FIRE FIGHTERS EMPLOYEE BENEFITS FUND

EMPLOYEE BENEFIT ENROLLMENT FORM

This form is to be used for benefit elections that must be made within the first 30 days of eligibility. Please complete ALL of the employee information and check the appropriate boxes to your choices. This form must be signed by the Employee.

EMPLOYEE INFORMATION: (PLEASE PRINT – ALL BLANKS MUST BE COMPLETED)

Last Name		First Name		MI	Social Security Number		
Street Address					Home Phone # None		
City		State	Zip Code	Male Female	Date of Birth	Marital Status	Date of Marriage
E-Mail Address		Cell Phone #		Spouse E-Mail Address (if applicable)			
Employment Date		Occupation		High Risk? Yes No		County ID#	Spouse Cell # (if applicable)
Are you covered by other insurance? Yes No		If yes, please provide name and address of Insurance Company:					

Please list ALL eligible dependents.

Last Name (If Different)	First Name	Social Security #	Date of Birth	Sex	Relationship	Dependent Disabled?	Coverage Desired		Has Other Insurance?
							Medical	Dental	

Please **Check** Coverage Desired (rates are Bi-Weekly)

	<u>Medical</u>		<u>Dental</u>		<u>HMO</u>		<u>PPO</u>
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	(\$261.26) _____	Employee & Family	(\$15.48) _____			(\$74.34)	_____

INDICATE TYPE OF COVERAGE YOU DESIRE:

Medical Plan

None Employee Only Employee + 1 Employee + 2 Employee + 3 or More

Dental Plan

None Employee Only Employee & Spouse Employee & Child(ren) Employee & Family CIRCLE ONE
HMO or PPO

Rejection of any Medical, Dental, or Vision benefits does not eliminate automatic participation in the Life Insurance benefit. 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.

Employee Signature X _____ Date _____

Benefits Fund Use Only (Do Not Write In This Area)

Frequency: _____ Bi-Weekly starting PPE _____/_____/_____ Effective Date of Action _____/_____/_____

OE _____ X _____/_____/_____

BENEFITS FUND AUTHORIZING SIGNATURE DATE
PBCFF EMPLOYEE BENEFITS FUND-GRP #76-410382



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) regardless of coverage.

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 your 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: _____