

PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

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	Date of Birth (mm/dd/yyyy)	
First Name	Last Name	MI	Dependent's SS#	Relationship			
				SPOUSE	SON	DTR	OTHER
				SPOUSE	SON	DTR	OTHER
				SPOUSE	SON	DTR	OTHER

TERMINATE DEPENDENT(S)			Medical	Dental	Both	Date of Birth (mm/dd/yyyy)	
First Name	Last Name	MI	Dependent's SS#	Relationship			
				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 Monthly)

<u>Medical w/o Medicare</u>	<u>Medical w/One Medicare</u>	<u>Medical w/Two Medicare</u>	<u>Retiree Dental</u>	<u>PPO</u>	<u>HMO</u>
Retiree Only (\$695.37) _____ (\$590.47) _____	Retiree Only (\$45.61) _____ (\$12.20) _____				
Retiree + 1 (\$1007.00) _____ (\$902.10) _____	Retiree + Spouse (\$96.05) _____ (\$21.34) _____				
Retiree + 2 (\$1,067.15) _____ (\$988.47) _____	Retiree + Child(ren) (\$120.39) _____ (\$26.42) _____				
Retiree + 3 or More (\$1,128.16) _____ (\$1,049.48) _____	Retiree + Family (\$161.08) _____ (\$33.54) _____				

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 _____ **DATE:** ____/____/____

<u>Benefit Fund Use Only</u> (Do Not Write In This Area)	
Frequency: Monthly starting ____/____/____	
EFFECTIVE DATE OF ACTION ____/____/____	
QE _____	X _____ / ____ / ____
REVIEWED _____	BENEFITS FUND AUTHORIZING SIGNATURE DATE PBCFF EMPLOYEE BENEFITS 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** - [mail to: info@mvffbenefts.com](mailto:info@mvffbenefts.com)



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: _____