

# 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	(\$707.00) _____	(\$573.00) _____		Retiree Only	(\$45.61) _____	(\$12.20) _____
Retiree + 1	(\$1018.00) _____	(\$884.00) _____	(\$750.00) _____	Retiree & Spouse	(\$96.05) _____	(\$21.34) _____
Retiree + 2	(\$1,078.00) _____			Retiree & Child(ren)	(\$120.39) _____	(\$26.42) _____
Retiree + 3	(\$1,139.00) _____			Retiree & Family	(\$161.08) _____	(\$33.54) _____
Add \$22.00 for each additional dependent over 3: _____ X \$22 = _____ + \$1139.00 = _____						

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 \_\_\_\_\_ / \_\_\_\_/\_\_\_\_

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 7<sup>th</sup> Place N  
WPB, FL 33411

Telephone: (561) 969-6663  
Fax: (561) 966-7760  
Email to: [info@myffbenefts.com](mailto:info@myffbenefts.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 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: \_\_\_\_\_