PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

2020 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) CIRCLE ONE: **ALL COVERAGE** **MEDICAL** **DENTAL**

NAME CHANGE: OLD NAME: ______________________ New Name: ______________________

Please Initial Coverage Desired (Rates are Bi-Weekly)

Medical			**Dental**	**HMO**		**PPO**	
Employee Only	($ 98.00)	_______	Employee Only	($ 5.63)	_______	($21.05)	______
Employee + 1	($205.00)	_______	Employee & Spouse	($ 9.85)	_______	($44.33)	______
Employee + 2	($234.00)	_______	Employee & Children	($12.19)	_______	($55.56)	______
Employee + 3	($273.00)	_______	Employee & Family	($15.48)	_______	($74.34)	______

Add $10.00 for each dependent over 3: _____ x $10 = ______ +$273.00 = _________

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: ______ 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 10/2019

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:** _________________