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)

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	($267.00) _____	Employee & Family	($15.48) _____	($74.34) _____

Add $10.00 for each Dependent over 3: _____ X $10 = _____ + $273.00 = _____

INDICATE TYPE OF COVERAGE YOU DESIRE:

Medical Plan

None Employee Only Employee + 1 Employee + 2 Employee + 3 Employee + _____

Dental Plan

CIRCLE ONE

None Employee Only Employee & Spouse Employee & Children Employee & Family 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

Revised 10/2019

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 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:** ______________