

Signature

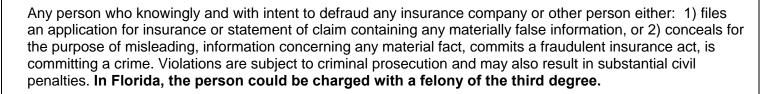
## IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND ENROLLMENT/CHANGE FORM – RETIREES

2024

A. EMPLOYEE INFORMATION (PLEASE PRINT)											
First Name			MI	MI Last Name					Social Security Number		
Street Address				City				State	Zip		
Telephon	10	N	larital Sta	itus	Gender	Date of Birth			Medicare Status		
		□ Singl □ Marri	ed		□ Male □ Female			Not Eligible Enrolled Medicare		Medicare#	
			estic Partr	ner							
Email:					Туре					Effective Date	
					□New Hire □ Othe		nge in Status er	Cancel/Waive			
B. PLAN ELECTIONS - RATES PER MONTH - CIGNA MEDICAL, VISION & DENTAL (BUNDLED)											
Non-Medicare Retirees Medicare Retirees											
	□Retiree Only \$ 250.00 □Retiree + Spouse \$ 555.00 □Retiree + Child(ren) \$ 475.00 □Retiree + Family \$ 750.00						□Retiree Only □Retiree + Spouse □Retiree + Child(ren) □Retiree + Family			\$ 250.00 \$ 555.00 \$ 475.00 \$ 750.00	
* I wish to cancel/waive coverage. (Continue to Page 2 or backside of this form.)											
C. DEPENDENTS I WOULD LIKE TO ENROLL											
As directed by the Centers for Medicaid and Medicare Services, Social Security Numbers need to be reported for each covered dependent below.											
Sex	Last Name, First Name, MI Social Security Number Date of Birth										
		,									
	Spouse									Medicare#	
	Dependent										
ΠF	Dependent										
□ M □ F	Dependent										
□ M □ F	Dependent										
□ M □ F	Dependent										
D. DEP	ENDENTS I WOUI	LD LIKE <sup>-</sup>	TO CAN	CEL							
Cancel named dependent:											
E. CONFIRMATION & VERIFICATION											
<ul> <li>I cannot change or revoke any of my elections at any time during this plan year unless I have a change in my family status (e.g. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of spouse, change in spouse's employer-sponsored health coverage, etc.). Notification of change must be received by the IAFF Local 587 Health Insurance Trust Fund within 30 days of the qualifying event.</li> <li>I understand the following requirements regarding dependent coverage:         <ul> <li>If I marry while covered under the plan and want to add my spouse, I must provide a marriage license within thirty (30) days of the event.</li> <li>If I need to add a newborn as a dependent, I must provide a birth certificate within thirty (30) days of birth.</li> <li>If I acquire a domestic partner, I must provide a domestic partner certificate within thirty (30) days of occurrence.</li> </ul> </li> <li>Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.</li> <li>If I do not complete a new Enrollment/Change Form before the start of each new plan year, it will be assumed that I have selected the same benefits as in the previous Plan Year.</li> </ul>											
□ I ELECT to participate in IAFF Local 587 Health Insurance Trust Fund as indicated on this form.											

DATE

## F. FRAUD STATEMENT





DATE

**WAIVER OF HEALTH INSURANCE** (continued from Section B)

NOTE: *RETIREES* OR *RETIREE WIDOW(ER)*, IF YOU WAIVE, OR CANCEL YOUR COVERAGE, YOU WILL NOT BE ABLE TO RE-ENROLL IN THE IAFF LOCAL 587 INSURANCE HEALTH INSURANCE TRUST.

□ Please check box if you wish to waive coverage.

By checking or marking the box above, I elect to cancel and waive my insurance coverage for myself and/or my family. I acknowledge and fully understand that if I decline or cancel health insurance coverage at any time, I am forfeiting my eligibility, and that I, and my dependents will not be able to return or re-enroll in the IAFF Local 587 Health Insurance Trust or the City of Miami Health Insurance.



DATE

Coverage summaries provided herein are intended as an outline of coverage only. Participants will receive a Summary of Benefits. In the event of any discrepancy between this brochure and the Summary of Benefits, the terms of the Summary of Benefits will control.

