IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND
ENROLLMENT/CHANGE FORM – RETIREES
2024

A. EMPLOYEE INFORMATION (PLEASE PRINT)

First Name	MI	Last Name	Social Security Number

Street Address	City	State	Zip

Telephone	Marital Status	Gender	Date of Birth	Medicare Status
	☐ Single ☐ Married ☐ Domestic Partner	☐ Male ☐ Female		☐ Not Eligible ☐ Enrolled _____ Medicare# _____

Email:	Type			Effective Date
	☐Open Enrollment ☐New Hire	☐ Change in Status ☐ Other_____	☐ Cancel/Waive Insurance*	

B. PLAN ELECTIONS - RATES PER MONTH - CIGNA MEDICAL, VISION & DENTAL (BUNDLED)

Non-Medicare Retirees		Medicare Retirees	
☐Retiree Only	$ 250.00	☐Retiree Only	$ 250.00
☐Retiree + Spouse	$ 555.00	☐Retiree + Spouse	$ 555.00
☐Retiree + Child(ren)	$ 475.00	☐Retiree + Child(ren)	$ 475.00
☐Retiree + Family	$ 750.00	☐Retiree + Family	$ 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	
☐ M ☐ F	Spouse			_____ Medicare# _____
☐ M ☐ F	Dependent			
☐ M ☐ F	Dependent			
☐ M ☐ F	Dependent			
☐ M ☐ F	Dependent			
☐ M ☐ F	Dependent			

D. DEPENDENTS I WOULD LIKE TO CANCEL

☐ **Cancel named dependent:** _____
☐ **Cancel named dependent:** _____
☐ **Cancel named dependent:** _____

E. CONFIRMATION & VERIFICATION

- 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.**
- I understand the following requirements regarding dependent coverage:
  - 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.
  - If I need to add a newborn as a dependent, I must provide a birth certificate within thirty (30) days of birth.
  - If I acquire a domestic partner, I must provide a domestic partner certificate within thirty (30) days of occurrence.
- 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.
- 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.

☐ **I ELECT to participate in IAFF Local 587 Health Insurance Trust Fund as indicated on this form.**

X _____ Signature

_____ **DATE**

F. FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person either: 1) files an application for insurance or statement of claim containing any materially false information, or 2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, is committing a crime. Violations are subject to criminal prosecution and may also result in substantial civil penalties. **In Florida, the person could be charged with a felony of the third degree.**

X _____ _____

Signature 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.

X _____ _____

Signature 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.

Any questions contact:
Benefits

305-425-1938

benefits@healthtrustmaff.org

Return to:
IAFF L587 Health Insurance Trust

2980 NW South River Drive
Miami, FL 33125

www.healthtrustmaff.org