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

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 ☐Change in Status ☐New Hire ☐Other _____	

B. Plan Elections – Medical , Dental, & Vision (Bundled) - Contributions Per Month

Non-Medicare Retirees		Medicare Retirees	
☐Retiree Only	$ 570.00	☐Retiree Only	$ 390.00
☐Retiree + Spouse	$1,240.00	☐Retiree + Spouse	$ 840.00
☐Retiree + Child(ren)	$1,050.00	☐Retiree + Child(ren)	$ 720.00
☐Retiree + Family	$1,630.00	☐Retiree + Family	$1,250.00

☐ No, I waive coverage. **(Continue to Page 2)**

C. Dependents I Would Like to Cover

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	Status	Coverage
☐ M ☐ F	Spouse			☐ Medicare Enrolled	Medical, Dental, & Vision
☐ M ☐ F	Dependent			☐ Over 26 Y/O	Medical, Dental, & Vision
☐ M ☐ F	Dependent			☐ Over 26 Y/O	Medical, Dental, & Vision
☐ M ☐ F	Dependent			☐ Over 26 Y/O	Medical, Dental, & Vision
☐ M ☐ F	Dependent			☐ Over 26 Y/O	Medical, Dental, & Vision
☐ M ☐ F	Dependent			☐ Over 26 Y/O	Medical, Dental, & Vision

Do dependents rely on you for support and maintenance? ☐Yes ☐ No Do they reside with you? ☐ Yes ☐ No

I affirm that all dependents listed meet the IRS Section 152 definition of "dependent" so that premiums can be paid with pre-tax dollars, if applicable.

Initials: _____

D. Cancel Dependents

☐ 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

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

NOTE: *RETIREE*S, IF YOU WAIVE 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.**

I elect to waive my insurance coverage to cover myself and/or family. I understand I will only be able to enroll during open enrollment or if an approved qualifying event occurs and I enroll within 30 days of the qualifying event and provide proof of previous coverage.

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 Manager

305-425-1938

benefits@healthtrustmaff.org

Return to:
IAFF L587 Health Insurance Trust

2980 NW South River Drive
Miami, FL 33125

www.healthtrustmaff.org