THE CITY OF MIAMI
HEALTH PLAN ENROLLMENT/CHANGE FORM

OFFICE USE ONLY	
☐ Executive	☐ General
☐ M &C	☐ Firefighters
☐ Unclassified	☐ Sanitation

ENROLLMENT INFORMATION

Status ☐ Active ☐ Retiree	**Plan Selection** ☐ Cigna Network Point of Service Plan ☐ Out of Area Plan (I certify that I live outside a network plan).	**EMAIL ADDRESS:**	**Effective Date:**
Type ☐ Open Enrollment ☐ New Hire ☐ Change in Status ☐ Other:_____			**Date of Hire**
First Name **MI** **Last Name**		**Social Security Number**	**Date of Birth**
Street Address		**City/State/Zip**	
Department	**Work Phone**	**Work Email Address**	**Home Phone**

MEDICAL, DENTAL, VISION ELECTIONS

TYPE OF ACTION					MEDICAL		DENTAL	
KEEP	ADD	CHANGE	CANCEL	TIER	CIGNA		CIGNA DPPO	CIGNA DHMO
☐	☐	☐	☐	Employee Only	☐		☐	☐
☐	☐	☐	☐	Employee & Spouse	☐		☐	☐
☐	☐	☐	☐	Employee & Child(ren)	☐		☐	☐
☐	☐	☐	☐	Family	☐		☐	☐

DEPENDENT ENROLLMENT

ENROLLMENT INFORMATION (Forms available for additional dependents)

Provide the following information for each dependent that should be insured for any of the above elections and list mailing address for any dependent that is different from the employee's as noted on the previous page.

COVERAGE SELECTION	TYPE	LAST NAME (if different from employee name)	FIRST NAME	MI	SEX M F	DATE OF BIRTH	SOCIAL SECURITY NUMBER	Student Yes No
☐ Medical ☐ Dental	Employee				☐ ☐			☐ ☐
☐ Medical ☐ Dental	Spouse				☐ ☐			☐ ☐
☐ Medical ☐ Dental	Child				☐ ☐			☐ ☐
☐ Medical ☐ Dental	Child				☐ ☐			☐ ☐
☐ Medical ☐ Dental	Child				☐ ☐			☐ ☐
☐ Medical ☐ Dental	Child				☐ ☐			☐ ☐

Cancel named dependent: _____ Medical ☐ Dental ☐

Have you included children/stepchildren over 26? ☐ Yes ☐ No If "yes", indicate names: _____

Are they dependent 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: _____

CONFIRMATION & VERIFICATION

- I cannot change or revoke any of my elections at any time during the plan year unless I have a change in 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 my spouse's employer-sponsored health coverage, etc.). **Notification of change must be 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 the birth.
  - If I acquire a domestic partner, I must provide a domestic partner certificate within thirty (30) days of such 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 the City of Miami's Health Care Plan as indicated on this form.

X _____ _____

EMPLOYEE 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.**

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.

WAIVER OF HEALTH INSURANCE

I ELECT TO WAIVE MY INSURANCE COVERAGE TO COVER MYSELF AND/OR MY 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 (FOR ACTIVE EMPLOYEES ONLY)

☐ **Please check box if you wish to waive coverage or if you are retiree see note below.**

NOTE: IF YOU ARE A RETIREE, AND YOU WAIVE YOUR COVERAGE, YOU WILL NOT BE ABLE TO RE-ENROLL IN THE CITY'S PLAN

X _____ _____

EMPLOYEE SIGNATURE **DATE**

Any questions contact Risk Management Group Benefits Division at (305) 416-1700

OFFICE USE ONLY Verification: _____/_____/_____ Data Entry: _____/_____/_____ Pay Period: _____/_____/_____ Initialed: