PINELLAS COUNTY RETIREE GROUP INSURANCE

Enrollment and Change Form

PERSONAL INFORMATION			
Last Name	First Name	Middle Initial	Home Phone
Mailing Address		Apt. Number	Cell Phone
City	State	ZIP	Social Security Number
Email			Retiree #

I AM CHANGING

- ☐ Medical Plan (non-Medicare eligible only)
- ☐ Dental Plan
- ☐ Add/Remove Dependents from coverage
- ☐ Group Term Life Insurance (decrease in coverage only)
- ☐ Group Term Life Beneficiary/ies
- ☐ My address, phone number or email

I AM CANCELLING

☐ Medical Plan ☐ Dental Plan ☐ Group Term Life Insurance

If you cancel coverage for yourself you may not re-enroll at a future date.

NEW ENROLLMENT OR CHANGE IN PLAN COVERAGE

HEALTH PLAN	*Health Coverage Level*	*DENTAL PLAN*	*Dental Coverage Level*
☐ Point of Service (POS)	☐ Retiree	☐ PPO Dental	☐ Retiree
☐ Consumer Driven with HSA	☐ Retiree + Spouse	☐ HMO Dental	☐ Retiree + 1
☐ Medicare Advantage	☐ Retiree + Child(ren)		☐ Retiree + 2 or more
Medicare eligible individual(s): _____	☐ Family		

ADD / REMOVE DEPENDENTS FROM COVERAGE

Health	Dental	Last Name	First Name	MI	Relationship	Gender M	Gender F	Date of Birth	Social Security Number	Add	Remove
☐	☐				Spouse	☐	☐			☐	☐
☐	☐					☐	☐			☐	☐
☐	☐					☐	☐			☐	☐
☐	☐					☐	☐			☐	☐
☐	☐					☐	☐			☐	☐

RETIREE LIFE INSURANCE Minimum $5,000; Maximum not to exceed 1X annual salary or $100,000, whichever is less.

Original Amount **Beneficiary/Beneficiaries Name(s)** **Relationship** **Address (if known)**

$_____ (Primary) _____

Reduced Amount (if over age 65) (Contingent) _____

$_____ ☐ Decline

The information provided above is true and correct to the best of my knowledge. I understand and accept the provisions on the reverse side of this form. I understand that if I cancel my coverage I will not be able to re-enroll in the plan.

Signature	Date Signed

Please do not complete below this line: HR USE ONLY

Coverage Effective Date	Premium Effective Date	Service Years	LDW	Other

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DOCUMENTATION REQUIREMENTS FOR COVERAGE CHANGES

After initial enrollment in the plan, changes are permitted during Pinellas County's annual enrollment period. During the plan year if you experience certain change of status events as shown below, your request for change and any required supporting documentation must be received in Employee Benefits no later than 31 days after the status event. The information on this page is a summary. Please refer to the group plan description for detailed information.

- **Change in legal marital status**
  Copy of marriage license, divorce decree or death certificate.
- **Change in the number of dependents (including birth, adoption or placement for adoption, death of a dependent, or dependent gains coverage elsewhere)**
  Copy of birth certificate, death certificate, court order of legal custody, or other documentation.
- **Change in employment status (resulting in gain or loss of eligibility for coverage for a spouse or dependent)**
  Copy of COBRA or HIPAA notice or letter from employer stating date eligibility and/or coverage will begin/cease.
- **Dependent satisfies or ceases to satisfy dependent eligibility requirements**
  Written documentation may be required including but not limited to certifications of financial dependency, proof of student status, court orders or other legal documents.

DEPENDENT ELIGIBILITY

- Dependent refers to the retiree's legal spouse, domestic partner, or a dependent child of the retiree or the retiree's spouse. The term “child” includes any of the following:
  - Natural child
  - Foster child
  - Stepchild
  - Child placed for adoption
  - Legally adopted child
  - Child for whom legal guardianship has been awarded to the retiree or the retiree's spouse
- The retiree must reimburse Pinellas County for any benefits that we pay for any dependent at a time when the dependent did not qualify for coverage.
- To be eligible for coverage under the policy, a dependent must reside within the United States.
- The definition of dependent is subject to the following conditions and limitations:

Maximum Age Eligibility for Children	
Health Plan	End of calendar year - age 26
Dental Plan	End of calendar year - age 24 DHMO, age 25 PPO

- A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.
- A dependent does not include anyone who is also enrolled as a retiree or an active employee.
- No one can be a dependent of more than one retiree or an active employee.

Submit completed signed form by mail, fax, or email to:

Human Resources Employee Benefits
400 South Fort Harrison Avenue, 4th Floor, Clearwater, FL 33756
Phone: (727) 464-4570 | Fax: (727) 464-5291
Email: employee.benefits@pinellascounty.org
(Please do not email forms that include social security numbers; use mail or fax instead.)

Human Resources
Helping U Succeed