

OPEN ENROLLMENT FOR PLAN YEAR 2011 (Retirees)

CITY OF VENICE GROUP INSURANCE

Read instructions & important information on reverse.

Please type or print firmly with black ink.

PERSONAL INFORMATION				
Last Name	First Name	Middle Initial		
Mailing Address Apt. Number				
City	State	Zip Code		
Email Address:				
Home Phone	Work Phone	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
HEALTH PLAN: BCBSFL, Inc.		DENTAL PLAN: FLORIDA COMBINED LIFE (BCBSFL, Inc.)		
<input type="checkbox"/> I wish to drop <input type="checkbox"/> Add a Dependent <input type="checkbox"/> Delete a Dependent <input type="checkbox"/> Keep current participation with no changes		<input type="checkbox"/> I wish to enroll in: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> I no longer wish to participate <input type="checkbox"/> I do not currently participate and am not eligible for this coverage		
Level of Coverage <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree +One <input type="checkbox"/> Family		Level of Coverage <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + One <input type="checkbox"/> Family		
NEW PLAN & PROVIDER for 2011 Current Dental coverage will not transfer <u>Only retirees currently participating in our dental plan may enroll in this plan. You must ALSO complete the attached Florida Combined Life Enrollment Form</u>				

√ if applicable Health Dental	Last Name, First Name, MI	Relationship	Gender M / F	Social Security #	Date of Birth	Dependent			
<input type="checkbox"/>	<input type="checkbox"/>	Same as above	Retiree						
<input type="checkbox"/>	<input type="checkbox"/>	Spouse							
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								

LIFE INSURANCE		<input type="checkbox"/> I wish to continue my retiree life insurance	<input type="checkbox"/> I wish to drop my retiree life insurance
RETIREE'S BENEFICIARY DESIGNATION	Primary (Name, Relationship, Address, if known)		
If to be split, _____% to each	Contingent		
	Contingent		

The information provided above is true and correct to the best of my knowledge. I understand & accept the provisions on the reverse side of this form.	
Signature	Date Signed

For Internal Use Only		
Health \$ _____	Dental \$ _____	Life \$ _____

PROVISIONS

DOCUMENTATION REQUIREMENTS FOR COVERAGE CHANGES

After initial enrollment in the plan, changes are permitted during the City's annual enrollment period. Changes at any other time may be made only for certain change of status events as shown below, and only if your request and any required supporting documentation is received in Retiree 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 and/or the pre-tax plan for detailed information.

Change in Legal Marital Status. Copy of marriage certificate, divorce decree or death certificate must be attached.

Change In the Number Of Dependents (including birth, adoption or placement for adoption, or death of a dependent). Copy of birth certificate, death certificate, court order of legal custody or other documentation is required.

Change In Employment Status (resulting in gain or loss of eligibility for coverage for a Retiree, spouse or dependent). Copy of COBRA or HIPAA notice or letter from employer must be attached stating date eligibility and/or coverage will begin/cease must be attached.

Dependent Satisfies (Or Ceases To Satisfy) Dependent Eligibility Requirements Written documentation may be required including but not limited to certifications, court orders or other legal documents must be attached.

Change in Residence (Outside Of Network Area). Must result in an individual gaining or losing eligibility. Written documentation must be provided.

Other: Explain and provide supporting documentation.

DEPENDENT ELIGIBILITY An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this plan:

The Covered Retiree's spouse under a legally valid existing marriage; dependent child of the Retiree or the Retiree's spouse, as set forth below:

The Patient Protection and Affordable Care Act (PPACA) legislation passed on March 23, 2010 and requires coverage be provided for dependent children up to age 26 without any qualification. Coverage will end at the end of the calendar year in which the child turns age 26. The Retiree will be required to submit a copy of the child's birth certificate naming the Retiree or the Retiree's spouse as the child's parent or appropriate court order/adoption decree, naming the Retiree or the Retiree's spouse as the child's legal guardian or custodian. Dependent children who have other job-based group health coverage available to them are not eligible under the City's health plan. The City will also continue to provide coverage for dependents age 26 to age 30 if the state mandated eligibility requirements are met.

The Retiree must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Retiree. No one can be a Dependent of more than one Retiree.