FINANCE & ADMINISTRATIVE SERVICES
Risk Management Division

CITY OF SUNRISE

Phone: (954) 572-2496
Fax: (954) 572-2382

May 16, 2016

Dear Retiree:

The City of Sunrise's Dental open enrollment period will begin on Monday, June 6, 2016 until Friday, June 17, 2016. It is during this time you are able to submit changes to dental insurance coverage for yourself and/or your dependents. MetLife/Safeguard will remain the administrator of the City's Dental Plan.

Please note: the next open enrollment for dental will be in conjunction with the medical and vision open enrollment held in late 2017.

Historically, the City of Sunrise has extended retirees the opportunity to select the City's dental benefits both on the initial retirement date and at each annual open enrollment. After July 1, 2016 retirees will have the option to continue dental benefits on their initial retirement date only. This open enrollment period for July 1, 2016 will be the last opportunity for existing retirees not currently covered to enroll in the City of Sunrise dental plans. Retirees may terminate coverage at any time.

If you would like to enroll or make changes please complete the attached enrollment/change form and pension deduction form, returning both to Risk Management by Friday, June 17, 2016 for an effective date of July 1, 2016.

Important: If you intend to add dependents, please provide documentation - enrollment forms cannot be processed without documentation proving a legal relationship/dependency. Proper documentation includes birth certificates, marriage certificates, court orders, social security numbers, and dates of birth. All changes will be effective July 1, 2016.

If you do not wish to make any changes for 2016/2017 – NO ACTION IS NECESSARY

DENTAL INSURANCE RATES FOR 2016/2017

Plan	Retiree Only	Retiree and 1 Dependent	Family
DHMO	$15.77	$27.61	$43.38
PPO-Low Option ($1,000)	$31.34	$59.36	$92.97
PPO-High Option ($2,000)	$49.05	$92.90	$145.49

If you have Life Insurance, we encourage you to review your beneficiary information, making any changes necessary. However, this can be done at any time during the year. **If you did not elect Life Insurance at the time of retirement, you may not do so.**

Risk Management is available to answer your insurance questions. Please contact Judy Mehrmann, Employee Benefits Specialist at 954-838-4528 and keep in mind that all enrollment forms must be returned to Risk Management by June, 17, 2016 for an effective date of July 1, 2016. We will accept e-mailed (jmehrmann@sunrisefl.gov), hand delivered or mailed forms.

Sincerely

Bill Mason
Risk Manager

Attachments:

- Enrollment/Change Form
- Pension Deduction Form
- Designation of Life Beneficiary Form

2016 Open Enrollment
Information and Enrollment Sessions

Dental open enrollment will begin June 6, 2016 and end June 17, 2016. This is the time to make changes to your dental insurance coverage for yourself and/or your dependents. It is also the time to update your beneficiaries. If you do not wish to make any changes for 2016/2017, no action is necessary on your part.

LOCATION: City Hall, City Commission Chambers, 10770 W. Oakland Park Blvd.

TIME: 10:00 AM – 2:00 PM

DATES:

Monday, June 6th
Wednesday, June 8th
Thursday, June91th
Friday, June 10th

Monday, June 13th
Wednesday, June 15th
Thursday, June 16th
Friday, June 17th

Benefit Summary

Plan	Participant Maximum	Preventive (exam, cleanings)	Basic Services (fillings)	Major Services (bridges/dentures)	Orthodontia (children under 19)
DHMO	**No Maximum**	**Refer to Plan Copayments**	**Refer to Plan Copayments**	**Refer to Plan Copayments**	**Refer to Plan Copayments**
PPO Low	**$1,000**	**100% of PDP Fee* (no deductibles)**	**80% of PDP*†**	**50% of PDP*†**	**50% of PDP***
PPO High	**$2,000**	**100% of PDP Fee* (no deductibles)**	**80% of PDP*†**	**50% of PDP*†**	**50% of PDP***

*PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums.

† Deductible of $50.00 individual and $150.00 family applies only to Type B & C Services.

NOTE: If You do not enroll for Dental Insurance for You and Your Dependents within 31 days of becoming eligible, and then enroll in the PPO plan, for the first Year, You and Your Dependents will only be covered for Preventive and Basic covered services. After the first Year, You and Your Dependents will be covered for all covered services.

The above is a brief summary of the available plans. If you would like additional information, please attend one of the enrollment sessions or contact Judy Mehrmann.

City of Sunrise Florida
Group Medical, Dental and Vision Plan

__New Enrollment __Reinstate
__Open Enrollment __Change

OFFICE USE ONLY Classification: **RETIREE**
Effective Date of Coverage:____/____/____

Subscriber Information

Retiree Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F

Mailing Address	Apt.	City	State	Zip	Phone ( ) _____- _____

Last Department/Division	Last Job Title			Email:

If this is a Change, Indicate Type: __Add Dependent(s) __Drop Dependent(s) __Drop Employee and Dependent(s), if any
(attach document for proof) **Changes must be made within 31 days of qualifying event, as per IRS Sec 125 guidelines**

__New address(as above), __New Name: From_____ to _____

This Change is due to: ___Marriage ___Birth ___Separation of Employment ___Other:_____ Date of Event: _____

Additional Information

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date? __Yes __No Dental? __Yes __No

If yes, list Covered Person(s):_____

Insurance Company Name: _____ Do you or your spouse have Medicare? __Yes __No

Covered Individuals	**Medical-HMO**	**Medical-POS**	**Dental-HMO**	**Dental-HMO**	**Dental-PPO Low Option**	**Dental-PPO High Option**	**Vision**
Indicate your medical, dental and/or vision coverage options by placing an X in the appropriate ( )	**Indicate Option**	**Indicate Option**	**Indicate Option**	**Retiree Facility #**	**Indicate Option**	**Indicate Option**	**Indicate Option**
Single	( )	( )	( )		( )	( )	( )
Retiree and One Dependent*	**N/A**	**N/A**	( )	**N/A**	( )	( )	**N/A**
Family	( )	( )	( )	**N/A**	( )	( )	( )

*Eligible dependents are: spouse and/or natural, adopted or awarded child as defined in the plan document.

List below **all** eligible dependents you wish to cover on your medica,dental or vision plan. This enrollment form will replace all previously completed forms. Only those listed below will have coverage on the effective date of this enrollment or change.

Last Name First M.I.	**Date of Birth**	**Gender**	**Social Security Number***	**Coverage Selection**
(2)Spouse	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(3) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(4) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(5) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(6) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____

Proper documents required: marriage certificate, birth certificate, hospital birth record, adoption award, medical child support order.

Authorization

I hereby (1) **REQUEST** coverage for the Group Medical, Dental and/or Vision Plan for which I am, or may become eligible; (2) authorize the Pension Administrator to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented. *The social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Retiree Signature _____ **Date**_____

Declination - complete this section only if declining or canceling your single coverage

I hereby **DECLINE** ___**Medical** ___**Dental** coverage. I realize that once I cancel my single medical and/or dental coverage, I may not elect the canceled coverage in the future. Coverage must be continued from the time of retirement and, if canceled, cannot be reinstated.

Retiree Signature _____ **Date**_____

CITY OF SUNRISE

PENSION DEDUCTION AUTHORIZATION

To Whom It May Concern:

This is authorization to deduct applicable insurance premiums to the City of Sunrise from my _____ pension each month with an effective date of 7/1/2016.
(Pension Plan)

Medical $_____ /Month

Vision $_____/Month

Dental $_____ /Month

Life $_____ /Month

_____ _____
Signature Date

_____ _____
Print Name Social Security Number

BENEFICIARY DESIGNATION FORM

Life Insurance Company of North America

CIGNA Group Insurance
Life · Accident · Disability

Employer Name CITY OF SUNRISE

Employee Name _____ **Employee Social Security #** _____

Current Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____ ***Please enter all dates in mm/dd/yyyy format.***

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Basic Life Insurance, Life Insurance Company of North America – Policy No. FLX 962492				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Employee's Contingent Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Basic Accident Insurance, Life Insurance Company of North America – Policy No. OK 964123				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Contingent(s):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**

Please refer to page 2 to designate Beneficiaries for Voluntary Basic and Accident Insurance and to review *Guidelines for Designation of Beneficiaries*. If you need additional space, using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

Voluntary Life Insurance, Life Insurance Company of North America – Policy No. FLX 962492				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Employee's Contingent Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Voluntary Accident Insurance, Life Insurance Company of North America – Policy No. OK 964123				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Contingent(s):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors – While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may wan to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary – You may designate a trust as a beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes – We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Community Property Laws – If you are married, reside in a community property state (Arizona, California, Hawaii, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature_____Date _____/_____/_____

Owner Signature_____Date_____/_____/_____