



BENEFITS MANAGEMENT

RETURN FORMS TO:

FBMC RETIREE & DIRECT BILL - Attn: Mail Slot 32
 PO Box 10789 Tallahassee, FL 32302-2789
 FBMC Service Center: 1-855-5MY-DCPS (1-855-569-3277)
 Direct Bill Fax: 866-836-9943 | Email: DirectBill@FBMC.com

2022 OVER 65 RETIREE ENROLLMENT FORM

DUVAL COUNTY PUBLIC SCHOOLS

January 1, 2022 - December 31, 2022

PLEASE WRITE IN ALL CAPITAL LETTERS WITH A PEN.

1. RETIREE INFORMATION

LAST NAME				FIRST NAME				MI	SSN				
HOME ADDRESS: STREET				CITY				STATE	ZIP				
BIRTH DATE: MM/DD/YY				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	HOME PHONE #				RETIREMENT DATE			
CELL PHONE #				EMAIL ADDRESS									

2. INSTRUCTIONS

Retirees: This form is only required if you are making changes. Subject to your continued eligibility, your elections will continue in the following plan years unless you change them. If you make any changes, you must complete the enrollment form in its entirety. **Medical Insurance and/or Standard Life Insurance cannot be elected if previously canceled.** You can cover your dependents under every benefit that specifies dependent coverage, as long as your dependents are currently covered and you participate in the same benefit. In the event you pass away while covering a dependent spouse and/or child(ren), coverage for the dependent(s) will terminate at the end of the month in which you pass away UNLESS the dependent is also a DCPS retiree. The dependent(s) will be extended the option of continuing coverage through COBRA.

3. FLEXIBLE BENEFITS

Indicate all benefit selections by entering the necessary information below. Dependent eligibility is limited to the same benefit categories and amounts selected by the Retiree. If you elect dependent coverage in any benefit, you must provide dependent information in Section 4.

DENTAL CARE	DeltaCare USA		Delta Dental		PREMIUM
	(Florida Residents Only)	(Non-Florida Residents Only)	PPO		
	Facility # _____				
Retiree Only	<input type="checkbox"/> \$21.84	<input type="checkbox"/> \$30.48	<input type="checkbox"/> \$44.08		
Retiree + 1	<input type="checkbox"/> \$36.58	<input type="checkbox"/> \$50.76	<input type="checkbox"/> \$87.76		
Retiree + Family	<input type="checkbox"/> \$53.82	<input type="checkbox"/> \$74.83	<input type="checkbox"/> \$114.39	<input type="checkbox"/> CANCEL	\$ _____
VISION CARE					PREMIUM
		Premiere Plan	Low Plan		
Davis Vision	Retiree Only	<input type="checkbox"/> \$7.62	<input type="checkbox"/> \$5.66		
	Retiree + 1	<input type="checkbox"/> \$16.28	<input type="checkbox"/> \$12.16		
	Retiree + Family	<input type="checkbox"/> \$23.08	<input type="checkbox"/> \$17.23	<input type="checkbox"/> CANCEL	\$ _____
HEARING CARE					PREMIUM
	Retiree Only	<input type="checkbox"/> \$8.00		<input type="checkbox"/> CANCEL	\$ _____
Ameritas - SoundCare®	Retiree + Spouse	<input type="checkbox"/> \$16.00			
	Retiree + Child(ren)	<input type="checkbox"/> \$12.00			
	Retiree + Family	<input type="checkbox"/> \$20.00			
IDENTITY THEFT PROTECTION					PREMIUM
	Premium Plan	<input type="checkbox"/> Retiree Only \$7.00	<input type="checkbox"/> Retiree + Family \$15.00	<input type="checkbox"/> CANCEL	\$ _____
ID Commander	Ultimate Plan	<input type="checkbox"/> Retiree Only \$10.50	<input type="checkbox"/> Retiree + Family \$22.50		
IT TECHNOLOGY SUPPORT					PREMIUM
	Unlimited Support Plan	<input type="checkbox"/> Retiree Only \$10.00		<input type="checkbox"/> CANCEL	\$ _____
IT Please	Unlimited Plus Support Plan	<input type="checkbox"/> Retiree Only \$14.00			
PET Rx					PREMIUM
PetPlus	<input type="checkbox"/> Single Pet \$4.50	<input type="checkbox"/> Multiple Pets \$8.50		<input type="checkbox"/> CANCEL	\$ _____
TOTAL					\$ _____

If you have an existing policy with Allstate, Unum, Aflac, or Trustmark and wish to change or cancel coverage, you must contact the providers directly. See the Retiree Reference Guide for contact information. Current premiums for voluntary benefits reflected on Current Benefits statement will continue until notification of a change from the Provider Company.

Please see reverse side for dependent information.
 Your signature is required on the back of this form in order to confirm your benefits.

4. DEPENDENT INFORMATION

DEPENDENT NAME (PRINT CLEARLY)	RELATION	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY #	DENTAL	DENTAL FACILITY #	VISION	HEARING

5. SIGNATURE

I UNDERSTAND THAT I CANNOT CHANGE MY ELECTIONS UNDER THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A PERMITTED MID-PLAN YEAR ELECTION CHANGE EVENT AS DEFINED IN THE RETIREE BENEFITS REFERENCE GUIDE. I UNDERSTAND AND AGREE THAT DCPS, THE UNION, AND FBMC BENEFITS MANAGEMENT INC., WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN ANY OF THE BENEFITS HEREIN OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM.

STATE LAWS REQUIRE AGENCIES THAT ARE REQUIRED TO COLLECT SOCIAL SECURITY NUMBERS (SSN) TO DISCLOSE THE PURPOSE FOR COLLECTING THE SSN. DUVAL COUNTY PUBLIC SCHOOLS IS ALLOWED TO COLLECT SSN'S WHEN SPECIALLY AUTHORIZED BY LAW TO DO SO, OR WHEN THE COLLECTION IS IMPERATIVE FOR THE PERFORMANCE OF THE DISTRICT'S DUTIES AND RESPONSIBILITIES. PURSUANT TO FEDERAL AND STATE LAWS, THE DISTRICT IS COLLECTING YOUR SOCIAL SECURITY NUMBER FOR THE PURPOSE OF PROCESSING RETIREE AND DEPENDENT BENEFITS; THIS COLLECTION IS MANDATORY. IF YOU DO NOT PROVIDE US YOUR SSN, DCPS CANNOT PROCESS YOUR APPLICATION/REQUEST. DUVAL COUNTY PUBLIC SCHOOLS WILL NOT DISCLOSE YOUR SSN TO ANYONE OUTSIDE OF THE DISTRICT EXCEPT AS AUTHORIZED BY LAW.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE. F.S. SECTION 817.234 (1) (b).

RETIREE PARTICIPANT SIGNATURE

DATE