

City of Miami



AFFIDAVIT OF SUPPORT

I, _____, hereby swear or affirm that my child(ren) _____ is (are) unmarried and is (are) primarily dependent upon me for financial support. I have provided this information for use by the City of Miami Health Plans for the purpose of determining eligibility for and participation in the City of Miami Health Plan by the aforesaid child(ren). I affirm that the information in this Affidavit of Support is true to the best of my knowledge and belief. I understand that any misrepresentation by me in this Affidavit may result in retroactive termination of coverage in City of Miami Health Plan and retroactive denial of claims previously processed.

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.

Employee's/Subscriber's Signature

Subscribed and Sworn/Affirmed personally before me, a Notary Public, on the _____ day of _____, 200__ by _____, who is
Employee's/Subscriber's Signature

Personally known to me or who has provided satisfactory proof of identification.

Notary Public

My Commission Expires: _____



Indicate your employee group	
<input type="checkbox"/> AFSCME	<input type="checkbox"/> MG/CONF
<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> UNCLASSIFIED
<input type="checkbox"/> FIRE	<input type="checkbox"/> SEA
<input type="checkbox"/> ACTIVE EMPLOYEE	<input type="checkbox"/> RETIREE

FOR CITY USE ONLY	
COVERAGE	_____
EFF DATE	_____
PAY PERIOD	_____
DED. CODE	_____

**CITY OF MIAMI
GROUP INSURANCE
ENROLLMENT/CHANGE FORM**

Section A: Employee Information			
Employee Name	Social Security #	Home Phone	Business Phone
Address (no)	(street)	(state)	(zip)
			County

Section B: Medical Plan Selection/Choose one of the following Medical Options:
<input type="checkbox"/> Option 1: Dual Choice (Indemnity and In-Network) <input type="checkbox"/> Option 2: Out-of-Area-I'm eligible because, I reside outside the network area <input type="checkbox"/> I choose to waive coverage. I understand that if I wish to join the program in the future, a "Statement of Medical Condition" will be required for myself and any dependent I wish to insure and based on such statement, my dependents and/or I may be denied coverage. Please note: If you are a retiree and cancel coverage for yourself re-enrollment would not apply.

Section C: List all persons to be enrolled. Enter Primary Care Physician(s) if you choose Option 1 or Option 2									
Last Name	First Name	Middle Initial	Birthdate Mo. Day. Yr.	Sex	Social Security Number	PCP or health care center for each member	Physician ID#	New Patient Yes	No
1. Employee									
2. Spouse									
3. First Dependent		Relationship							
4. Second Dependent		Relationship							
5. Third Dependent		Relationship							
6. Fourth Dependent		Relationship							

I have a dependent that is a student disabled (Attach documentation)

Section D: Employee Pre-Tax Election
I authorize the City of Miami to convert a portion of my salary to pay the contributions I would otherwise be required to make towards the City's health care coverage on a before-tax basis. I understand that I may not change my payroll deduction elections during the plan year except as allowed by Internal Revenue guidelines.
Signature _____ Date _____

Section E: Retiree Deduction Authorization
I authorize the appropriate City of Miami Retirement Trust to deduct group benefit contributions each month from my pension check in the amount sufficient to cover my contributions towards health/or life coverages. I am aware that the rates are based on the claims experience of the City program and that the rates charged may be subject to change. This authorization does not replace specific authorizations required by individual Pension Boards or Retirement Trusts.
Signature _____ Date _____

Section F: CIGNA'S Authorization Clause
The information provided above is true and correct to the best of my knowledge. I also authorize release to or by CIGNA or to their representative, and hospital, medical or other insurance information concerning myself or any of my dependents which may be required to process my claim, or to administer an insurance case management survey for subrogation purposes, or coordination of benefits. I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers. I authorize payment of benefits to the Participating Provider of the benefits.
Signature _____ Date _____

Section G: To be completed by the Office of Group Benefits
Check One: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> Retirement <input type="checkbox"/> Cancel all dependents <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Add dependent(s) <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Cancel named dependent <input type="checkbox"/> Cancel Named coverage <input type="checkbox"/> Change in EE Group <input type="checkbox"/> Reinstatement of coverage <input type="checkbox"/> Other
Effective Date _____ Date of hire _____