Village of North Palm Beach

Village Retiree Insurance Continuation Declaration Form

I acknowledge that I, _____, am aware that I may
(Print retiree name)
elect to continue my medical and/or dental insurance with the Village of North Palm Beach as a participant in their group health insurance plans as applicable under the Village's "Retiree Insurance Benefits Policy" (#2007-02 attached).

In accordance with the terms and conditions of the policy, I acknowledge that:

- I cannot change my current elections at this time except to drop spouse/dependent and that I must wait until the Village's next regularly scheduled annual open enrollment period to make any other changes;
- I must keep the Village apprised of my current mailing address so that I may be duly notified of annual open enrollment periods;
- I must pay the Village's full monthly premium due for my election coverage(s) as provided for by their health care provider agreements and ***that the amount may change subject to the terms and conditions of the group health care plans***;
- I may ask Human Resources for information concerning these plans at any time;
- I may only elect to change my plan options during annual open enrollment periods;
- My selection of a plan is my own and that the Village cannot influence my selection;
- **I must pay the entire premium as due <u>prior</u> to the first day of the month for which coverage is applicable each and every month in order for coverage to continue.** (This means that if I fail to properly remit payment prior to the first day of the month for which the payment is applicable, my coverage <u>will</u> be cancelled for that month); and
- If I do not elect to continue my coverage at this time or if I elect to drop my coverage and/or fail to properly pay for my coverage at any time in the future, that I will <u>not</u> be allowed to rejoin the Village of North Palm Beach's group health care plan(s).

My current mailing address is:

_____

_____

My current insurance elections as I will continue them are:

Medical Provider _____

Plan _____

Monthly premium due _____

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Dental Provider _____

Plan _____

Monthly premium due _____

My first premium amount of _____ is due to the Village before
(monthly premium cost)

_____ and will cover my insurance for _____.
(due date of 1st premium) (effective month of retiree coverage)

Please mail / deliver payments to: **Attention: Human Resources Dept.**
Village of North Palm Beach
501 US Highway One
North Palm Beach, FL 33408

The next anticipated open enrollment period will be in: _____
(month / year)

Please check with Human Resources for more information as this time approaches.

_____ _____
Employee Signature Date

Checked by:

_____ _____
(Human Resources) Employee Signature Date