THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

2027 OPEN ENROLLMENT

RETIREE with ADULT CHILD NOTICE

Applicable to those children over age 26

In order to add or continue coverage for your adult child (to age 30), you MUST enroll/re-enroll your adult child by completing the Dependent Coverage Enrollment/Affidavit Form and provide the supporting documentation to the Benefits Department. The Dependent Verification Process is required for enrollment of unverified dependents (please see further details regarding this process below).

Florida Statute 627.6562(2) makes special provisions for a dependent adult child who has reached the age of 26 and becomes uninsured. This Florida law allows a dependent child to remain covered in the plan to the **end of the calendar year in which age 30 is reached** for the purpose of medical (health) insurance.

You may add or continue to cover your dependent adult child on the **Health Plan** until the end of the calendar year in which the adult child reaches the age of 30, if the child:

- is unmarried and has no dependents
- is a resident of Florida or a full or part-time student; and
- is not provided with other insurance coverage and is not entitled to Medicare (Title XVIII of the Social Security Act)

Important Note: Enrollment of the employee/parent of the adult child in one of the District's Health Plans is **REQUIRED**, in order to enroll or maintain health coverage for the adult child. If the health coverage of the employee/parent of the adult child is terminated, the coverage for the adult child will also be termed.

If the dependent becomes ineligible to remain on the plan, the dependent **MUST** self-report and coverage will end the last day of the month the notification occurs or the end of the month the District becomes aware the dependent is no longer eligible to remain enrolled in the plan.

You will have a choice of five (5) great Medical Plan options. Please review the **2027 Aetna Health Booklet** for further details on the Health Plan options, which can be located on the Benefits Department website at www.browardschools.com/benefits by clicking on the **Open Enrollment 2027** link.

There will be **no** rate increases for dependents enrolled in the Medical Plans for 2027. The Premier Choice HSA Plan will continue to provide retirees who cover dependents with an option to reduce their out-of-pocket monthly dependent premium cost.

The premium rates for retirees with dependent coverage are listed below:

2027 Adult Child 26-30 Plan Monthly Premiums

Premier HMO	$1,336.72
Premier Plus HMO	$1,548.40
Premier Choice HSA	$1,115.24
Kids Basic Plan (1 Child)	$ 884.18
Kids Enhanced Plan (1 Child)	$1,481.56

If you are covering other dependents on your plan, the Adult Child Plan dependent premium is in addition to the premium you are currently paying for your other dependent(s) through direct pay to Benefits Outsource Inc. (BOI) or deductions from your checking or savings account. You will be sent a separate bill for the Adult Child Plan. Payment MUST be made directly to BOI on behalf of Aetna or through the ACH payment program with BOI or the Aetna FRS Payroll Authorization you may have already established.

Dependent Verification (Action Required if Enrolling *Unverified* Dependents)

In a continuous effort to improve the managing of its Benefits Program, the District requires the completion of the **Dependent Verification Process** to ensure all dependents enrolled in the Health, Dental and Vision Plans, meet the District's established **Dependent Eligibility Criteria**.

Add or Re-Enroll a *Verified* Dependent(s) to the Adult Child 26-30 Health Plan

- You are **NOT** required to re-verify your dependent(s). You should have received confirmation that your dependent was verified with the Benefits Department.
- You are required to submit, **in order to add or re-enroll your verified dependent (annually in October)**, a copy of **one of the following documents, along with the completed attached Adult Child Affidavit Form** to certify that your adult child has met the criteria to be enrolled in the plan, in accordance with Florida Statutes 627.6562(2).
    - Proof of Florida residency (e.g. Driver's License)
    - Proof of full or part-time school registration
- **Both** the **Adult Child Affidavit Form** and one of the above noted documents, **MUST** be received in the Benefits Department at 7770 W. Oakland Park Blvd., Sunrise, FL 33351 or by email to **benefits@browardschools.com** by **Friday, October 23, 2026**
- Failure to submit the **above noted required Form and one of the requested certified documents** by the stated deadline, will result in your dependent(s) **not being added or removed from the plan, effective, January 1, 2027**.

Add an *Unverified* Dependent(s) to the Adult Child 26-30 Health Plan

- You **MUST verify** your dependent(s) with the Benefits Department by **Wednesday, October 21, 2026 by 5:00 p.m.** by emailing the **Dependent Verification Document(s), along with the completed Dependent Verification Form** to the Benefits Department to **benefits@browardschools.com**. One of the applicable documents **must** be submitted, in order to verify your dependent's eligibility: **original Birth Certificate, Adoption, or Legal Guardianship Records, Marriage Certificate and Birth Certificate (for a stepchild)**.
    - Please be advised, documents written in languages other than English **MUST** be translated into English by a certified Translation Company. You may log-on to **www.naces.org** to select an accredited translation company. The closest company in South Florida, which provides this service is: **Josef Silny, 7101 SW 102nd Avenue, Miami, FL 33173; 305-273-1616 or www.jsilny.com.**
- You are also required to submit **upon enrollment of your dependent and annually in October**, a copy of **one of the following documents, along with the completed attached Adult Child Affidavit Form**, in order to certify that your adult child has met the criteria to be enrolled in the plan, in accordance with Florida Statutes 627.6562(2).
    - Proof of Florida residency (e.g. Driver's License)
    - Proof of full or part-time school registration
- The **Adult Child Affidavit Form** and the **above noted documents**, **MUST** be received in the Benefits Department at 7770 W. Oakland Park Blvd., Sunrise, FL 33351 or by email to benefits@browardschools.com by **Friday, October 23, 2026**
- Failure to **verify your dependent(s)** and submit the **above noted required Form**, along with **one of requested certified documents** by the stated deadline, will result in your dependent(s) **not being added to the plan, effective, January 1, 2027**.

Information regarding the Dependent Verification Process and Requirements can be located on the Benefits Department's website at **browardschools.com/benefits** by clicking the **Open Enrollment 2027** link. After reviewing your documents, staff will provide you with confirmation that the Dependent Verification Process has been completed.

Premium Billing

You will receive payment information from Benefits Outsource, Inc. (BOI), which will reflect the premium amount due. For those who are currently enrolled in automatic debit (ACH) program, payments from your checking or savings account will continue at the **2027 premium rate(s)** for your current or new benefit elections. Payment should be made directly to BOI**, not to The School Board of Broward County, Florida**.

BROWARD COUNTY PUBLIC SCHOOLS
2027 OPEN ENROLLMENT
RETIREE EMPLOYEE with ADULT CHILD
DEPENDENT COVERAGE ENROLLMENT/AFFIDAVIT FORM
(AGE 26 - 30)
Florida Statute 627.6562(2)

EMPLOYEE INFORMATION

Name: _____ Personnel #: _____

Address: _____ City: _____ State: _____ Zip: _____ Gender ___

Phone#: _____ Social Security#: _____ Date of Birth: _____

DEPENDENT INFORMATION

Name of Dependent Last	First	MI	Sex M/F	SSN	DOB	AETNA KIDS Basic ✓	KIDS Enh. ✓	Premier HMO ✓	Premier Plus HMO ✓	Premier Choice (HSA) ✓
						☐	☐	☐	☐	☐

Address: _____ City: _____ State: _____ Zip: _____

Name of educational institution attending (if applicable): _____ Attending Full-Time ☐ or Part-Time ☐

By checking **ALL** the below, I hereby certify that the dependent identified above:

☐ is my child; and
☐ is unmarried; and
☐ has no dependent(s) of his or her own; and
☐ is a resident of the State of Florida or a full-time or part-time student; and
☐ does not have other insurance coverage and is not entitled to Medicare (Title XVIII of the Social Security Act)

I recognize that this affidavit is a legally binding document and accept full responsibility for notifying the Broward County Public Schools' Benefits Department immediately if there are any changes pertaining to this child's status as my dependent. If my dependent was **not previously verified through Verification Process**, I will present or submit by the required deadline, to the Benefits Department, the **Dependent Verification Document(s)** in the form of **one** of the following: **Birth Certificate, Adoption, or Legal Guardianship Records, Marriage Certificate and Birth Certificate (for a stepchild)**, along with the completed **Dependent Verification Form**, in order to verify my dependent's eligibility. I have attached **one** of the following supporting documentations: **proof of Florida residency or proof of full or part-time school registration** to certify that my dependent has met the Florida Statutes 627.6562(2) criteria. I agree to provide the documents listed or any other documents, when requested by BCPS or its insurers at any time as long as the child is enrolled as my dependent. I understand that I may be responsible for any expenses paid by BCPS or its insurers for the child that I enroll and is not eligible to participate in BCPS's benefits programs and that my providing false or misleading information about the dependent status of my child to BCPS or its insurers may be grounds for disciplinary action, including termination of employment. I hereby certify, under penalty of perjury, that the information provided by me is true and correct to the best of my knowledge. I understand that Benefits Outsource, Inc. (BOI) will send me an invoice or premiums taken through the ACH program will continue, which I enrolled in.

Employee Signature: _____ **Date:** _____
(Month, Day, Year)

SWORN TO and subscribed before me this _____ day of _____, 20 _____ , by

_____ . Such person: (Notary Public check applicable box)

☐ is personally known to me. ☐ produced a current driver's license. ☐ produced _____ as identification.

Notary Public Signature: _____

(NOTARY PUBLIC SEAL)

Notary Public Name: _____

Return completed Form and required document(s) to: **Benefits & Employment Services Department 7770 W. Oakland Park Blvd., Sunrise, FL 33351**

You may also send by email to: benefits@browardschools.com