

2027 Pre-Medicare Retiree Enrollment Change Form

Benefits Changes Effective January 1, 2027

INSTRUCTIONS: Complete this form to make changes for 2027. Choose **one selection per benefit section** by placing an "X" in the Selection column. Any area not completed will result in those benefits remaining as they currently are.

Retiree Information

Full Name: _____	Date of Birth (MM/DD/YYYY): ____ / ____ / ____	Employee ID: _____
Phone Number: (____) ____ - _____	Email Address: _____	Last 4 Digits of SSN: _____
Mailing Address: _____		

Tobacco Surcharge Attestation

☐ I DO NOT use tobacco products (Standard rates apply)	☐ I USE tobacco products (\$50.00 monthly surcharge will be added)
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Medical Insurance — UnitedHealthcare

Dental Insurance — Humana

**Rates shown are non-tobacco monthly rates (\$50 surcharge applies if tobacco user).*

Select	Plan Name	Coverage Level	Monthly
☐	Low HMO	Retiree Only	\$846.00
☐		Retiree + Child(ren)	\$1,202.00
☐		Retiree + Spouse	\$1,319.00
☐		Retiree + Family	\$1,589.00
☐	High HMO (HMO)	Retiree Only	\$936.00
☐		Retiree + Child(ren)	\$1,386.00
☐		Retiree + Spouse	\$1,506.00
☐		Retiree + Family	\$1,846.00
☐	CDHP - High Deductible	Retiree Only	\$736.00
☐		Retiree + Child(ren)	\$1,092.00
☐		Retiree + Spouse	\$1,174.00
☐		Retiree + Family	\$1,448.00
☐	DECLINE MEDICAL COVERAGE		\$0.00

Select	Option & Plan	Coverage Level	Monthly
☐	Opt 1: DHMO Enhanced (Network FL only)	Retiree Only	\$16.18
☐		Retiree + Child(ren)	\$34.38
☐		Retiree + Spouse	\$28.31
☐		Retiree + Family	\$44.49
☐	Opt 2: DHMO Basic (Network FL only)	Retiree Only	\$12.29
☐		Retiree + Child(ren)	\$26.29
☐		Retiree + Spouse	\$21.38
☐		Retiree + Family	\$33.66
☐	Opt 3: PPO High	Retiree Only	\$35.91
☐		Retiree + Child(ren)	\$98.74
☐		Retiree + Spouse	\$87.99
☐		Retiree + Family	\$132.87
☐	Opt 4: PPO Low	Retiree Only	\$28.31
☐		Retiree + Child(ren)	\$77.86
☐		Retiree + Spouse	\$69.37
☐		Retiree + Family	\$104.76
☐	DECLINE DENTAL COVERAGE		\$0.00

Vision Insurance — EyeMed

Select	Plan Name	Coverage Level	Monthly
☐	EyeMed Vision	Retiree Only	\$5.45
☐		Retiree + Family	\$14.00
☐	DECLINE VISION COVERAGE		\$0.00

For 2027, all currently enrolled Spouses, Domestic Partners and Stepchildren need to be verified.

Please see Mandatory Dependent Audit Instructions.

2027 Newly Added Dependent(s) Form

Supplemental Enrollment Form for Dependents

Dependents who are not eligible for Medicare may enroll independently for coverage as long as the Medicare Eligible Retiree has enrolled in one of the FSRBC plans.

Retiree Verification

Print Retiree's Full Name: _____	Retiree ID / Last 4 SSN: _____
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Dependent Information

Print Dependent's Full Name	Date of Birth (MM/DD/YYYY)	Relationship (Spouse / Child)	Last 4 of SSN	Enrollment Selection (Mark 'X' to Enroll)
1. _____	___ / ___ / ____	[] Spouse/DP [] Child	_____	[] Medical [] Dental [] Vision
2. _____	___ / ___ / ____	[] Spouse/DP [] Child	_____	[] Medical [] Dental [] Vision
3. _____	___ / ___ / ____	[] Spouse/DP [] Child	_____	[] Medical [] Dental [] Vision
4. _____	___ / ___ / ____	[] Spouse/DP [] Child	_____	[] Medical [] Dental [] Vision

SECURITY NOTICE: Social Security information is required. Please be aware that standard emails are not secure. For your protection, if including sensitive personal details, we suggest mailing or faxing this form.

Dependent Enrollment Guidelines

- A dependent may be added to an existing plan of a retiree who is not Medicare Eligible.
- A dependent of a retiree who is enrolled in an FSRBC plan may enroll using this form if the dependent is not eligible for Medicare.
- You must clearly print all dependent information in the table above.
- Dependent relationship to retiree must be verified (refer to dependent verification guidelines on the district website).
- Submit required verification documents along with this enrollment form.
- Children from birth through 25 years of age are eligible to be enrolled as dependents subject to relationship verification.

SPECIAL ENROLLMENT NOTE: A separate application is required to enroll a Domestic Partner, Child(ren) of a Domestic Partner, or Adult Children aged 26–30. Visit the Retiree website to download information and application forms for these types of enrollment.

Acknowledgment & Signature

- Selections are effective January 1, 2027. Retirees may cancel benefits at any time during the plan year by submitting the request in writing. Changes take effect the first of the month following notification.
- Declining coverage will restrict future re-enrollment.
- Voluntary termination of benefits does not grant COBRA continuation rights.
- Domestic partners are not eligible for COBRA continuation and must enroll in Medicare as soon as they become eligible.

Signature: _____ Date: ___ / ___ / ____

RETURN FORM NO LATER THAN NOVEMBER 16, 2026 TO:

The School District of Palm Beach County, 3300 Forest Hill Blvd., Suite A103, West Palm Beach, FL 33406

Attn: Miriam Morales | Email: Miriam.Morales@palmbeachschools.org | Fax: 561-434-8103