PLAN YEAR 2027
PART-TIME EMPLOYEE
FLEXIBLE BENEFITS ENROLLMENT FORM

Please print in **ALL CAPS** using a black or blue pen. Refer to your online 2027 Benefits at **www.mdcpsbenefits.com** for a complete description of benefits and rates.

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Employee ID	Last Name	First Name	MI	Email Address	Gender	Birth Date (MM/DD/YYYY)
					❒M ❒F	

Home Address (Street)	County	State	Zip	Phone Number

OFFICE USE ONLY	Social Security Number	Effective Date	1st QA by & Date	Entered by & Date	2nd QA by & date	B.U.	Due Date
	___-___-___						

2 INSTRUCTIONS

You must complete an enrollment form to enroll in flexible benefits. Make a copy for yourself. Return your completed form with your first monthly premium, made payable to FBMC Benefits Management and mail to: FBMC Benefits Management, Inc., M-DCPS, PO Box 12241, Miami, FL 33101.

3 BENEFITS

Indicate your selections by checking the appropriate box for benefits, type of coverage and level desired. Dependent eligibility is limited to the same benefit categories and amounts you select. If you elect dependent coverage in any benefits, you must provide dependent information in Section 4 below.

					MONTHLY COST
DELTACARE USA DHMO	**STANDARD**	**HIGH**	**Dental Facility # (Required)**		
Employee Only	☐ $9.14	☐ $14.79			
Employee & Family	☐ $23.26	☐ $37.75	_____		
DELTA DENTAL PPO	**STANDARD**	**HIGH**			
Employee Only	☐ $25.26	☐ $40.72			
Employee & Family	☐ $77.37	☐ $121.78			
HUMANA DENTAL DHMO	**LOW**	**HIGH**	**Dental Facility # (Required)**		
Employee Only	☐ $8.27	☐ $11.08			
Employee & Family	☐ $21.19	☐ $28.45	_____		
HUMANA DENTAL PPO	**STANDARD**	**HIGH**			
Employee Only	☐ $30.19	☐ $48.67			
Employee & Family	☐ $92.47	☐ $145.54			
EYEMED VISION	Employee Only ☐ $6.88		Employee & Family ☐ $17.19		
METLIFE AURA IDENTITY THEFT PROTECTION		**PROTECTION PLAN**	**PROTECTION PLAN PLUS**		
	Employee Only	☐ $5.25	☐ $7.95		
	Employee & Family	☐ $8.95	☐ $12.95		
ARAG LEGAL PLAN	Employee & Family ☐ $13.08				
THE STANDARD SHORT-TERM DISABILITY Evidence of Insurability (EOI) may apply.	Employee Only	Standard ☐ $9.17	Standard Upgrade ☐ $14.76		
THE STANDARD LONG-TERM DISABILITY Evidence of Insurability (EOI) may apply.	Employee Only ☐ $21.55				
METLIFE HOSPITAL INDEMNITY COVERAGE	**DAILY BENEFIT**	**$50 PER DAY**	**$150 PER DAY**		
	Employee Only	☐ $1.81	☐ $5.37		
	Employee & Family	☐ $4.57	☐ $13.55		
THE STANDARD VOLUNTARY TERM LIFE INSURANCE					
Employee Only	☐ $10,000	☐ $20,000	☐ $30,000	☐ $40,000	☐ $50,000
	☐ $60,000	☐ $70,000	☐ $80,000	☐ $90,000	☐ $100,000
THE STANDARD ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)					
This benefit is not offered to employees represented by AFSCME.	☐ Employee	Coverage Amount $ _____			
	☐ Employee & Family	Coverage Amount $ _____			
				Total Monthly Premium	$

IF YOU HAVE SELECTED DEPENDENT COVERAGE, COMPLETE THE INFORMATION BELOW AND YOU MUST SUBMIT DEPENDENT DOCUMENTATION FOR ALL COVERED DEPENDENTS, IF NOT PREVIOUSLY SUBMITTED.

4 DEPENDENT INFORMATION

ELIGIBLE DEPENDENT'S NAME (Last Name, First Name, MI)	BIRTH DATE	RELATION-SHIP	GEN-DER M/F	SOCIAL SECURITY #	CHECK THE BOXES OF DEPENDENT COVERAGE SELECTIONS: Dental	EyeMed Vision	ID Watch-dog	HIC	Legal	Dental Facility #

I agree to complete and submit to any provider of health services such consents, releases and other assignments as are reasonably necessary for any provider, in accordance with its rights under the Group Agreements, to be subrogated to my rights or a family member's rights or to coordinate with other health benefit plans or insurance policies. In addition, I authorize any provider of health services to provide, upon written request, any information concerning the health condition, or treatment, of any covered person whenever such information is considered necessary for the proper disposition of a claim submitted for payment in fulfillment of obligation. I agree for myself and other covered members of my family to be bound by the benefit, deductibles, copayments, exclusions, limitations, and other terms of the Group Agreement.

The Salary Reduction amount specified above will continue in effect until I submit a new Salary Reduction Authorization for a subsequent enrollment, terminate employment, take an unpaid leave of absence from employment or discontinue or modify my Employee-Paid Benefits in a subsequent enrollment. I UNDERSTAND AND AGREE THAT MY EMPLOYER (M-DCPS), UNION, AND FBMC BENEFITS MANAGEMENT, INC. WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATING IN THE FLEXIBLE BENEFITS PLAN OR DUE TO MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Employer (M-DCPS) or Employer's designee to serve benefits on behalf of employees, in accordance with Section 627.569 Florida Statutes, as amended. **Any person who knowingly and with the 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).**

5 SIGN HERE

Employee SIGNATURE	DATE SIGNED

MAKE A COPY OF THIS FORM FOR YOUR RECORDS.