FBMC BENEFITS MANAGEMENT
Retiree and Direct Bill Department
P.O. Box 10789
Tallahassee, FL 32302-2789
Fax: (850) 514-5803

COLLEGE of CENTRAL FLORIDA

RETIREE ENROLLMENT/CHANGE IN STATUS FORM

Plan Year January 1, 2024 through December 31, 2024

LAST NAME	FIRST NAME	MI	HOME PHONE

SOCIAL SECURITY NUMBER	HOME ADDRESS (STREET)	CITY	STATE	ZIP
___ - ___ - ____				

BIRTH DATE (MM/DD/YY)		EMAIL ADDRESS
	☐ Male ☐ Female ☐ Single ☐ Married	

ENROLLMENT STATUS				REP	EFFECTIVE DATE
☐ New Retiree	☐ Open Enrollment	☐ Change In Status	☐ Administrative Adjustment		

OFFICE USE ONLY

FORM INSTRUCTIONS: All eligible Retirees must complete an Enrollment Form to receive desired coverage. You must complete this entire Enrollment Form and return it to Employee Benefits to ensure enrollment in the benefits selected.

When choosing coverage, please check one box per section below. Costs are shown calculated on a monthly basis.

MEDICAL COVERAGE OPTIONS	BlueOptions PPO Gold 03359	BlueOptions PPO Silver 05774	Deduction
Retiree Only	☐ $703.00	☐ $642.00	
Retiree +Spouse/Dependent	☐ $1,477.00	☐ $1,348.00	
Retiree + Child	☐ $1,266.00	☐ $1,156.00	
Retiree + Family	☐ $2,040.00	☐ $1,862.00	
	☐ Add Coverage ☐ Drop Coverage ☐ Keep Coverage		
MEDICARE SUPPLEMENTAL PLAN OPTIONS	BlueOpti Medicare Supplemental Plan Florida Blue 78800		Deduction
Retiree Only	☐ $307.44		
Spouse Only	☐ $307.44		
Retiree +Spouse	☐ $614.88		
	☐ Add Coverage ☐ Drop Coverage ☐ Keep Coverage		

VOLUNTARY LIFE INSURANCE OPTIONS	Standard Insurance		
	Select on of the following:		Deduction
	Level of Coverage	Cost of Coverage	
Plan 1- Basic Life & AD&D	☐ $ 5,000	$ 15.25	
	☐ ADD Coverage ☐ Drop Coverage ☐ Keep Coverage		

PLEASE READ AND SIGN REVERSE

DEPENDENT INFORMATION

Instructions: All eligible dependents must be listed here to be covered. Proof is required to add any eligible dependent.

Last Name	First Name	MI	Relationship	Sex	Social Security #	Disabled	Medical	Dental	Vision

BENEFICIARY INFORMATION

To make changes to your beneficiary information please contact the HR department at (The COLLEGE OF CENTRAL FLORIDA).

I hereby authorize FBMC Benefits Management, on behalf of The COLLEGE OF CENTRAL FLORIDA, to deduct the cost of my benefits each month as designated (by ACH, FRS, or check). I understand and agree that FBMC Benefits Management Inc., and The COLLEGE OF CENTRAL FLORIDA will be held harmless from any liability resulting from either my participation in The COLLEGE OF CENTRAL FLORIDA Benefits or my failure to sign or accurately complete this enrollment form.

I represent that the statements on this application are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions. I understand that this enrollment form is hereby made a part of the group contract. I understand that 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. F.S. Section 817.234(1)(b) (2001).

_____ _____

Retiree Signature Date

_____ _____

Benefits Administrator Signature Date

PLEASE READ AND SIGN REVERSE