2017 OPEN ENROLLMENT
NEWLY ELIGIBLE ADULT CHILD DEPENDENT
ENROLLMENT DEADLINE: NOVEMBER 29, 2016
BENEFITS EFFECTIVE: JANUARY 1, 2017 – DECEMBER 31, 2017

Dear M-DCPS Employee:

This is a changes only enrollment. Our records indicate that your child dependent currently enrolled under your healthcare plan turned age 26 during this plan year. In order to continue coverage for the 2017 plan year, you must request a newly adult child dependent package and return it, along with the required documentation, by the enrollment deadline. Failure to return the package by the deadline will result in the termination of your dependent's healthcare coverage effective December 31, 2016.

Important Rules Governing Dependent Coverage:
Under Florida law, an Adult Child dependent, ages 26-30, may be considered an eligible dependent for the purpose of "health" insurance. A provision in the Patient Protection and Affordable Care Act (PPACA) Healthcare Reform allows for a child dependent to be covered under the employee's healthcare plan until the dependent turns age 26. At that time, the dependent will be deemed an Adult Child. The School Board will continue to provide coverage as a regular child through the end of December 31, 2016.

You may **only** continue or add your dependent coverage until the end of the calendar year if the child:

- is dependent upon you for support;
- is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

To obtain the Newly Eligible Adult Child Dependent Package, visit www.dadeschools.net, under Highlights click on 2017 Benefits, then click on the Notices/Forms icon, then click on the "Newly Eligible Adult Child Dependent Package." The completed package must be submitted with the following dependent eligibility documentation:

- Affidavit of Eligibility
- Birth certificate or court documents of adoption/guardianship/legal custody
- Social Security Number
- Driver's License

Adult Dependent Healthcare Premiums:

CIGNA HEALTHCARE	PER PAY RATE ADULT DEPENDENT CHILD		
	10 Month	11 Month	12 Month
Open Access Plus (OAP) 10*	$385.80	$321.50	$296.77
Open Access Plus (OAP) 20	$366.00	$305.00	$281.54
LocalPlus	$365.40	$304.50	$281.08

NOTE: *OAP 10 will only be offered to dependents currently enrolled in the plan. AFSCME employees are not eligible for OAP 10.

If you have questions or need additional information, please contact the Office of Risk and Benefits Management at 305-995-3883 or 305-995-7129, Monday – Friday, 8:00 a.m. – 4:30 p.m. Your completed enrollment form and required documentation must be received by the **November 29, 2016** deadline for coverage effective **January 1, 2017.**

FBMC
BENEFITS MANAGEMENT

ACTIVE ADULT CHILD
2017 ENROLLMENT FORM

Please print using a black or blue ink pen. Make a copy for your records.

1. EMPLOYEE INFORMATION

EMPLOYEE NAME (LAST) (FIRST) (MI)			HOME PHONE	FAX NUMBER	
SOCIAL SECURITY #	HOME ADDRESS (NO. & STREET)		CITY	STATE	ZIP
E-MAIL ADDRESS	DUE DATE	EFF DATE	PRD DATE	RECEIVED DATE	PROCESSED DATE

2. HEALTHCARE PLAN SELECTION

CIGNA HEALTHCARE PLAN* (check one)	**Cost Per Pay/Per Covered Adult Child****		
	10 MONTH	**11 MONTH**	**12 MONTH**
☐ OAP 10 ***	$385.80	$321.50	$296.77
☐ OAP 20	$366.00	$305.00	$281.54
☐ LocalPlus	$365.40	$304.50	$281.08

If you are covering other children under age 26:

* Your adult child must be covered under the same healthcare plan as yourself.

** The premium for the adult child is in addition to the children/family rate.

*** OAP 10 will only be offered to dependents currently enrolled in the plan.

3. ADULT CHILD DEPENDENT INFORMATION

Name	DOB	Social Security Number	Relationship	Gender	Cost Per Pay
					$
					$

Please add my adult child(ren) listed above to the healthcare plan selected. I understand that if I cover more than one eligible adult child, the cost per month is per adult child and that my adult child(ren) must be covered under the same healthcare plan as me. If I cover other children under age 26, I understand that this cost is in addition to any other child(ren) premium.

To re-enroll your currently enrolled adult child, the following dependent eligibility documentation must be submitted with your completed enrollment form prior to the dependent being added to your healthcare coverage:

- Affidavit of Eligibility
- Birth certificate or Court Documents of Adoption/guardianship/legal custody
- Proof of Florida Residence (Florida Driver License)

To enroll your newly eligible adult child, you must provide proof of loss of creditable coverage within 63 days, in addition to the required eligibility documentation listed above.

I have completed all required information above and I have included the required adult eligibility documentation with this election form. Furthermore, I understand that if I do not provide the required information and eligibility documentation, this form will not be processed and my adult child will not have healthcare coverage effective January 1, 2017. I also understand that I will not be able to add my adult child until next open enrollment, at which time proof of creditable coverage will be required.

You may FAX form and documents to FBMC Benefits Management at 305.995.1425, U.S. MAIL to P.O. Box 12241, Miami, FL 33101, or SCHOOL MAIL to WL 9112.

SIGN HERE	EMPLOYEE SIGNATURE	DATE SIGNED

Keep a copy for your reference.

AFFIDAVIT OF "ADULT CHILD" ELIGIBILITY

I, _____, M-DCPS Employee Number _____, hereby swear or affirm that I am the natural or adoptive parent, step-parent (natural child of spouse or domestic partner), legal guardian or custodian of _____, who is between the ages of 26 and 30.

I further swear or affirm that the above mentioned dependent child:

- Is dependent upon me for support;
- Is living in my household, or is a full-time or part-time student;
- Is unmarried and does not have any dependent children of his or her own;
- Is a resident of the State of Florida or a full-time or part-time student; and
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefit plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

I have provided this information for use by FBMC for the purpose of determining eligibility of my adult dependent child for and participation in the M-DCPS sponsored healthcare plans. I affirm that the information in this Affidavit of Support is true to the best of my knowledge and belief. I understand that any misinterpretation by me or my dependent in this Affidavit may result in retroactive termination of coverage in any and all M-DCPS healthcare plans (as applicable) and retroactive denial of claims previously processed.

_____
EMPLOYEE SIGNATURE

Subscribed and Sworn/Affirmed personally before me, a Notary Public, on the _____day of_____, year, by _____, who is personally known
(Print Employee Name)
to me or who has provided satisfactory proof of identification.

_____
Notary Public

My Commission Expires: _____