SGI-12
01/15

Dependent Eligibility Certification Form

People First
STATE OF FLORIDA HR

If you cover dependents under *any* State Group Insurance plan, you **must** certify their eligibility by completing this form before any changes to your insurance can be processed.

In accordance with Chapter 60P, Florida Administrative Code, dependents must meet specific eligibility requirements to be covered under State Group Insurance plans. Eligible dependents include:

- Your **spouse** – a person to whom you are legally married. The term "spouse" does not include common law marriage partners, registered domestic partners or other partners of relationships not defined as marriage under the law of the state or foreign county in which they were entered.
- Your **child** – your biological child. Dependent children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **child with a disability** – your covered child who is permanently mentally or physically disabled. This child may continue health insurance coverage after reaching age 26 if you provide adequate documentation validating disability upon request and the child remains continuously covered in a State Group Insurance health plan. The child must be unmarried, dependent on you for care and for financial support, and have no dependents of their own.
- **Legal guardianship** – a child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **grandchild** – a newborn dependent of your covered child. Coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered.
- Your **Legally Adopted child** – your legally adopted child pursuant to a Judgment of Adoption; or a child placed in your home for the purpose of adoption in accordance with applicable state and federal laws. Dependent children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **foster child** – a child that has been placed in your home by the State of Florida Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **stepchild** – the child of your spouse for as long as you remain legally married to the child's parent. Dependent children may be eligible through the end of the calendar year in which they reach 26, potentially longer if they are disabled.
- Your **over-age dependent** – your child after the end of the calendar year in which they turn age 26 through the end of the calendar year in which they reach 30, if they are unmarried; have no dependents of their own; are dependent on you for financial support; live in Florida or attend school in another state; and have no other health insurance.

Based on the definitions above, please list all eligible dependents below that are currently covered under ANY state insurance plan or those you want to add to a plan(s). If you do NOT list a covered dependent, the dependent will be removed from coverage as of the first of the month following this notification if you are requesting a QSC (Qualified Status Change), or as of January 1 if this is an Open Enrollment Change. Attach enrollment forms as necessary. * Required to be completed.

*Name (Last, First, MI) Please Print	*Social Security Number	*Date of Birth	*Gender	*Relation

I hereby affirm and attest that the dependent(s) listed above meet the requirements of eligibility. If any dependent is determined to be ineligible or I fail to notify People First of a loss of eligibility or any supporting documentation is not provided upon request, I understand that I may be liable for any and all claims paid for any dependent deemed ineligible.

***People First ID Number:** | 0 | | | | | | | |

***Signature**_____ ***Date**_____

SGI-10
08/13

Spouse Program Election Form

People First
STATE OF FLORIDA HR

Learn about plans, use the cost estimators and more at myflorida.com/mybenefits. For help, call (866) 663-4735 or TTY (866) 221-0268 weekdays, from 8 a.m. to 6 p.m. Eastern time.

SECTION A Primary Spouse (Policyholder) Information - REQUIRED FIELDS*

People First ID* 0

Date of Birth (MMDDYYYY)*

Gender* M F

Area Code – Primary Phone

Area Code – Alternate Phone

First Name*

Last Name*

Suffix

Home Address Line 1*

Home Address Line 2

Home County*

City*

State*

ZIP Code*

Country*

Notification E-Mail Address

☐ **Check this box if your mailing address is the same as your home address.**

Mailing Address Line 1*

Mailing Address Line 2

City*

State*

ZIP Code*

Country*

SECTION B Event Type - Please check (✓) appropriate box.

What type of event is this? ☐ Open Enrollment ☐ Qualifying Status Change (QSC) Event (see attached chart)

QSC Code: _____ QSC Event: _____ QSC Date: _____

SECTION C Spouse Program Information

Preferred Provider Organization (PPO) plans allow you to visit doctors in and out of the Florida Blue network; however, your cost may be much greater if you select one out of network. Health Maintenance Organization (HMO) plans only provide coverage within the provider network, except for certain emergencies. You must live or work in the HMO service area county to be eligible for the HMO network. PPO and HMO plans both offer pharmacy benefits.

Health Investor Health Plans are high deductible plans with lower monthly premiums for Career Service employees. You may enroll in a Health Savings Account (HSA) and receive a monthly contribution from the state. Fill out the Tax-Favored Accounts form and open a HSA bank account at Tallahassee State Bank to be eligible for the HSA benefit.

If you and your spouse are active state employees, you are both eligible for health insurance coverage at a reduced monthly premium, provided you apply within 60 days of your qualifying event.

Section C continued on page 2

Spouse Program Election Form

People First ID*

0

SECTION C continued Spouse Program Information

To enroll, both spouses must complete and sign this form. One spouse must be designated "primary" and the other "secondary." The primary spouse is the policyholder. The secondary spouse and eligible dependents are covered under the primary spouse's coverage. Both spouses must enroll in the same health plan.

To cancel, the effective end date of participation in the Spouse Program shall be as of the first day the parties became ineligible to participate in the Spouse Program.

Both spouses must contact the Service Center within 60 days of becoming ineligible for the Spouse Program if one or both terminate state employment, retire, divorce, or in the event of death.

Note: In the event of divorce, covered dependent children are added to the primary spouse's plan, and the secondary spouse is enrolled in a separate family coverage policy. If there are no dependent children, each spouse is enrolled in individual coverage.

SECTION D State Group Health Insurance - Please check (✓) your choice(s).

Enter your requested effective date:

(must be the first day of the month)

If you select an HMO that is not in your county, you will be enrolled in the State Employees' PPO plan. Go to www.myflorida.com/mybenefits to see HMOs by county.

☐ Standard PPO Plan

☐ Standard HMO - Print Plan Name _____

☐ Health Investor[1] PPO Plan

☐ HMO Health Investor[1] Plan - Print Plan Name _____

[1]Out-of-pocket annual deductible amount is $1,250 for individual coverage and $2,500 for family coverage before anything is covered except some preventive care.

SECTION E Secondary Spouse Information - REQUIRED FIELDS*

People First ID*

0

First Name*

Last Name*

Suffix

Home Address Line 1*

Home Address Line 2

Home County*

City*

State*

ZIP Code*

–

Country*

Notification E-Mail Address

Spouse Program Election Form

People First ID*

0							

SECTION F Dependent Enrollment (Attach additional page if necessary)

Complete all fields in the chart below and then check the appropriate column to **ENROLL**, to **CONTINUE** coverage for eligible dependents, or to **CANCEL** coverage for dependents. Go to myflorida.com/mybenefits for dependent eligibility requirements.

To complete the Relation column, use the number that describes your dependent(s):

1 - Spouse 2 - Child 3 - Legal Guardianship 4 - Grandchild 5 - Legally Adopted Child 6 - Foster Child 7 - Stepchild 9 - Over-age Dependent

Note: Secondary employee and any children enrolled will be covered under the primary employee.

Name (Last, First, MI) Please Print	Social Security Number									Date of Birth (mm/dd/yyyy)	Gender	Relation	Enroll	Continue	Cancel

SECTION G Employee Certification

I hereby affirm and attest that the dependent(s) listed above meet the requirements of eligibility. If any dependent is determined to be ineligible or I fail to notify People First of a loss of eligibility or any supporting documentation is not provided upon request, I understand that I may be liable for any and all claims paid for any dependent deemed ineligible.

I understand the options I am choosing and that my participation is subject to applicable rules in Chapter 60P, Florida Administrative Code. I understand that my elections will remain in effect for the remainder of the calendar year and can only be changed during open enrollment or if I have a Qualifying Status Change event as defined by the Federal Internal Revenue Code and/or the Florida Administrative Code. I understand that I must make all changes through People First. Allowable changes include enrolling, changing plans, canceling coverage, and adding or dropping dependents. I understand that I must send this election form directly to the People First Service Center and enrollment changes cannot be processed if I send forms and/or applications to the insurance company. I understand I must request such changes within 60 calendar days of the Qualifying Status Change event. I authorize payroll deductions of the required contributions.

Primary Employee Signature* _____ **Date*** _____

Secondary Employee Signature* _____ **Date*** _____

Mail this completed form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314 or fax to (800) 422-3128

Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. People First is required to refer such cases to the State of Florida.

Qualifying Status Change (QSC) Event Chart

QSC Code	QSC Name	Documentation Requirement
1	Change in legal marital status (marriage, divorce or death).	Divorce decree, death certificate.
2	Change in the number of subscribers dependents (birth, adoption, placements, judgments decrees, court orders, death, dependent no longer meets eligibility).	Adoption papers, any official court ordered document, death certificate.
3	Commencement of employment or other change in employment that triggers eligibility (new hire, LWOP and return after one full calendar month, termination of spouse's employment if you were a covered dependent.	PAR
4	Termination or other change in employment status that causes loss of eligibility (death of subscriber).	Death certificate.
5	Change in residence or work location that triggers a loss of eligibility for subscriber or dependent.	PAR, recertification of dependent(s) eligibility.
6	Significant cost increase or decrease of at least $20.00 (change in FTE, LWOP, FMLA, Optional life age banding, legislative mandates).	PAR
7	Significant reduction of coverage (with or without loss of coverage).	DSGI approval.
8	Gain or loss of other group coverage (military leave, Medicare, Medicaid, healthy kids (government subsidized insurance).	PAR, copy of Medicare card.
9	Other allowable changes see the QSC matrix.	www.myflorida.com/mybenefits

Revised 09.06.12