Department of MANAGEMENT SERVICES
Division of State Group Insurance

Spouse Program Election Form

Learn about plans, use the cost estimators and more at mybenefits.myflorida.com. 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*

Date of Birth (MMDDYYYY)*

Gender* ☐ M ☐ F ☐ Other

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 Chang (QSC) Event (see attached chart)

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

SECTION C Spouse Program Information

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.

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. Changing the primary spouse is permitted only during Open Enrollment or under a QSC event.

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 People First Service Center within 60 days of becoming ineligible for the Spouse Program if one or both terminate state employment, retire, or in the event of divorce.

Spouse Program Election Form

SECTION C continued

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 individual coverage policy. If there are no dependent children, each spouse is enrolled in individual coverage.

Preferred Provider Organization (PPO) plans allow you to visit doctors both in-network and out-of-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 to be eligible for the HMO plans. PPO and HMO plans both offer pharmacy benefits.

If you enroll in a High Deductible Health Plan, both spouses are also eligible to enroll in a Health Savings Account. Each spouse will receive the monthly individual state contribution and each spouse can make payroll contributions up to half of the family maximum.

Maximum annual contributions to your Health Savings Account are determined by the IRS each year. Each spouse can make payroll contributions up to half of the family maximum. See the Savings and Spending Accounts Comparison Chart for limits on the annual maximum.

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 selected 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 service area.

☐ PPO Standard Plan

☐ PPO High Deductible Health Plan

☐ HMO Standard - Print Plan Name _____

☐ HMO High Deductible Health Plan - Print Plan Name _____

If you elected a high deductible health plan above, you can designate the amount each spouse would like to contribute to an HSA through payroll deduction. The amount listed below should be the annual contribution amount.

☐ Primary Spouse HSA Contribution Amount _____

☐ Secondary Spouse HSA Contribution Amount _____

SECTION E Secondary Spoouse Information - REQUIRED FIELDS*

People First ID*

First Name*

Last Name*

Suffix

Home Address Line 1*

Home Address Line 2

Home County*

City*

State*

Zip Code*

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Country*

Notification E-Mail Address

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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 www.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* _____

Seconday Employee Signature* _____ Date* _____

Log in to your People First account at PeopleFirst.myflorida.com, select the “Submit” icon in the top right corner and follow the steps to upload the completed form to the People First Service Center. Alternatively, you can mail the form People First Service Center • PO Box 6830 • Tallahassee, FL 32314

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 Florida Division of State Group Insurance.

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, Leave Without Pay and return after one full calendar month, termination of spouse's employment if you were a covered dependent.	Personnel Action Request
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.	Personnel Action Request, recertification of dependent(s) eligibility.
6	Significant cost increase or decrease of at least $20.00 (change in FTE, Leave Without Pay, Family Medical Leave Act, Optional life age banding, legislative mandates).	Personnel Action Request
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).	Personnel Action Request, copy of Medicare card.
9	Other allowable changes see the QSC matrix.	myBenefits.MyFlorida.com

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