

Dear State of Florida Retiree:

Congratulations on your retirement! As a new retiree, you need to know all of the insurance benefit options available to you. Please read each section carefully.

**Section A: Summary of options to continue your current coverage**

- Health—continue through COBRA for 18 months or elect retiree coverage
- Basic Life—choose either the \$2,500 or the \$10,000 benefit (Optional Life is not available)
- Dental and Vision—continue through COBRA for 18 months
- Other Supplemental Plans—contact your insurance company about converting your policy or buying an individual plan
- Health Savings Account—make contributions until Medicare eligible, but the state will no longer make contributions
- Medical Reimbursement Account—continue through the end of the calendar year if the balance is taken out of your sick and annual leave
- Dependent Care Reimbursement Account—ends with your last employee payroll deduction, but you can file claims that were incurred prior to your termination date

**Section B: In the mail**

When your personnel office completes the retirement process for you, you should receive two packets by mail:

**1. COBRA rights information packet:**

- **Health:** Federal law (COBRA) provides that insured employees and their covered dependent(s) may continue group health coverage for up to 18 months from the date employment ends or until the you become covered under another group plan, whichever is first. We are required by law to notify you of your COBRA rights.
- **Supplemental Dental and Vision:** The enrollment forms in your COBRA information packet have information about your current state dental and/or vision plans (if any). You can only continue your dental and/or vision plans under COBRA provisions.

**2. Retiree enrollment packet (enclosed with this letter):**

- **Your Benefits Statement:** Shows your current insurance coverage with the state. Please carefully review this statement and the benefit messages.
- **New Retiree Health and Life Insurance Election Form:** Use to continue or end your coverage as a retiree. You must enroll within 31 days of your last day of work if you are currently enrolled in health and/or life insurance. You must also send the appropriate payments to remain covered (see Section C).

- **Premium Chart:** Shows retiree premium rates for the Preferred Provider Organization (PPO) Plan and Health Maintenance Organizations (HMO) Plans.
- **Personal Health Information Authorization Form:** Complete this form to give another person, such as your spouse, authorization to speak to People First about your benefits.

**Section C: To continue your coverage if you currently have insurance benefits**

❖ **Make smart choices:**

- **You must make health and life insurance elections through the State Group Insurance Program within 31 days after your employment ends. If you do not, you will not be able to enroll at a later time.**
- Review your enclosed benefits statement to see your coverage options. Upon retirement, you can change coverage levels (family to individual, for example) but you can only change plans if you have an appropriate qualifying event, such as moving out of an HMO service area, or during open enrollment.
- Contact the insurance carriers directly to convert your supplemental policies or to buy an individual plan. Go to [MyFlorida.com/MyBenefits](http://MyFlorida.com/MyBenefits) for contact information.
- Call the People First Service Center at (866) 663-4735. TTY users call (866) 221-0268 for help with using People First.
- If you and your spouse are both State of Florida retirees with no eligible dependents, think about changing your level of coverage from family to two individual policies. This may be cheaper than the family plan.
- If your spouse is an active State of Florida employee, you should become a dependent under your spouse's health plan. You will be able to enroll in retiree health insurance later when your spouse retires or ends state employment; however, to keep life insurance, you must enroll now.

❖ **Complete the enclosed New Retiree Insurance Election Form to continue coverage as a retiree.** If you call the Service Center and make your choices over the phone, you don't need to complete the form. Mail and fax information are on the form.

❖ **Send the required premium payments for each month of coverage.** To continue state health and/or life as a retiree, you must send a personal check, money order, or cashier's check for the first month of coverage. Write your People First ID number on your payment, made payable to Division of State Group Insurance, and send it to:

People First Service Center  
 PO Box 863477  
 Orlando, FL 32886-3477

You can pay up to six months in advance, but you must pay by the 10<sup>th</sup> of the month for the next month's coverage; for example, payments for July coverage are due to the Service Center by June 10<sup>th</sup>. To enroll before sending your payment, call the Service Center. If your payment is not received by the 10<sup>th</sup>, your coverage will be suspended

for the next month and you will not be eligible for services until the full payment is received. If your payment is not received by the last day of the month in suspension, your coverage will be cancelled and you will not be able to re-enroll.

If you will receive a Florida Retirement System (FRS) pension payment from the Division of Retirement, your premiums can be deducted if your monthly pension is sufficient to cover the cost. You must submit monthly payments until your retirement benefit payments begin. Please call the Division of Retirement toll free at (888) 377-7687 to verify the start of your retirement benefit pension payment; Tallahassee residents call 488-4742. People First will start the deductions from your retirement benefit upon notification (election form or phone call).

- ❖ **Submit your application for the Health Insurance Subsidy.** The health insurance subsidy is an employee benefit of the Florida Retirement System. Retirees who carry any form of qualified health insurance receive a monthly supplemental payment based on years of service. As an FRS Pension Plan retiree, the HIS-1 form will be sent to you in the "Retiree Packet" from the Retired Payroll Section. Therefore, if you are continuing your State Group Health Insurance as a retiree or if you are a covered dependent of State Group Health Insurance under your spouse, complete this form and send it to:

People First Service Center  
PO Box 6830  
Tallahassee, FL 32314

Or fax: (904) 828-6092

People First will process this form to certify to FRS that you have State Group Health coverage and return it to the Division of Retirement.

Investment Plan members are eligible for the HIS benefit only if they meet certain requirements. Go to <http://www.myflorida.com/frs/forms/new/forms.htm#investmentplan> to learn more.

Note: If your retiree health insurance coverage will be strictly through a private vendor or Medicare, follow the instructions for submittal on the HIS-1 form. People First can only certify State Group Health Insurance coverage.

- ❖ **We can send you coupons to pay directly.** Call the Service Center if you are a retiree under an optional retirement plan or if your FRS benefit, including the Health Insurance Subsidy, will not cover your monthly health and life insurance premium deductions. If your check will not cover both, you should have your life insurance deducted from your retirement benefit and pay your health insurance directly.
- ❖ **If you are enrolled in a medical reimbursement account, you can continue your benefit through the end of the calendar year.** Complete and submit an FSA Medical Reimbursement Account-Termination of Employment Form, located at [MyFlorida.com/MyBenefits](http://MyFlorida.com/MyBenefits) in the Forms and Publications sections. This form gives you the option of paying the balance of your account on a pretax basis from your sick or

annual leave payment, or you can pay by personal check on a post-tax basis. Once you make the election, you will have until the end of the reimbursement period to file claims.

#### **Section D: To cancel your coverage**

- ❖ **Complete the enclosed New Retiree Insurance Election Form** within 31 days after your employment ends to cancel your health and/or life plans.

**You should know:** If you decide not to continue your plans within this time frame, ***you will not be allowed to join at a later date as a retiree.*** Program guidelines are clear that if you opt out of health and life insurance benefits at the time of retirement, you cannot re-enter the State Group Insurance Program unless you are re-employed with the state. If your spouse will continue to be actively employed, you can be covered as a dependent under your spouse's health plan. If your spouse leaves employment, you can change your health coverage at that time.

- ❖ **To cancel your medical reimbursement account,** complete and submit the FSA Program Medical Reimbursement Account-Termination of Employment Form located on the People First Web site.
- ❖ **Dental, vision and other supplemental plans** will automatically end the last day of the month following your termination date; for example, if your termination date is June 10, your coverage will end July 31.

#### **Section E: Medicare information**

Once you retire and become eligible for Medicare Part A and Part B due to age (65) or disability, you should contact the Social Security Administration (SSA) about your Medicare benefits. Enrollment in Medicare is time sensitive and you may be subject to substantial financial penalties if you fail to meet federal deadlines. Contact your local SSA office three months before your 65<sup>th</sup> birthday: call 800-MEDICARE (800-633-4227), or visit [www.Medicare.gov](http://www.Medicare.gov) for more information. TTY users call (877) 486-2048.

If the SSA determines you are Medicare eligible, the State Group Insurance Plan will pay health insurance claims secondary to (after) Medicare, even if you don't sign up for or purchase Medicare Part B, medical. This also applies to dependents on your plan who are eligible for Medicare. Failure to buy Medicare Part B means you will have significant out-of-pocket expenses for Part B eligible services because you will be required to pay the portion (approximately 80 percent) that Medicare would have paid. If you choose to continue your state health insurance coverage once you're eligible for Medicare, you should elect your Medicare Part B coverage. Although Medicare does not require you to purchase Part B, it is in your financial interest to do so.

**For proper enrollment and claims processing, send a copy of your Medicare ID card to the Service Center as soon as you get it from the SSA.**

If the SSA determines you are not eligible for Medicare at age 65, send a copy of your Medicare ineligibility letter to the Service Center to ensure your health insurance coverage continues without interruption. Mail copies of Medicare documentation with your People First ID number to:

People First Service Center  
PO Box 6830  
Tallahassee, FL 32314  
Or fax (904) 828-6092.

**Section F: Important reminders**

- ❖ **Special Life Insurance Provisions for Total Disability.** If your retirement is due to your having become totally disabled as defined by the State Life Insurance Plan, regardless of whether you elect service retirement or are approved for disability retirement, you may be eligible for extended death benefits. Call People First to ask about qualifying and applying for these extended death benefits.
- ❖ **Home address:** Be sure to keep your home address up to date in People First to receive open enrollment materials and other important information timely.
- ❖ **Use the Web site:** You can log in to People First to see your benefits information. Go to Health & Insurance > Your Benefits. To see your monthly premium payments go to Health & Insurance > Premium History and select the month you want to see. Remember to keep your password updated every 90 days so that you can use the system during open enrollment or to make changes for qualifying events.

If you have questions about your insurance benefits upon retirement, please call us at (866) 663-4735 or TTY (866) 221-0268. We are open Monday through Friday, from 8:30 a.m. to 5:30 p.m. Eastern Time.

Sincerely,  
People First Service Center

## RETIREE HEALTH INSURANCE PREMIUM RATE CHART

Locate your county and see checkmarks to determine available plans. Then go to page 2 (PPO) or 3 (HMO) to find the premium amounts for your coverage level. Your premium is based on whether you're (1) enrolled in a Standard or HIHP plan, (2) less than age 65 or 65+, and (3) covering just yourself or your entire family.

County Name	State's PPO Plan	AvMed	Capital Health	Florida Health	United Health	Vista	County Name	State's PPO Plan	AvMed	Capital Health	Florida Health	United Health	Vista
Alachua	✓	✓			✓	✓	Lee	✓	✓			✓	
Baker	✓	✓			✓		Leon	✓		✓		✓	✓
Bay	✓				✓		Levy	✓	✓			✓	✓
Bradford	✓	✓			✓	✓	Liberty	✓				✓	✓
Brevard	✓				✓		Madison	✓				✓	✓
Broward	✓	✓			✓	✓	Manatee	✓				✓	
Calhoun	✓				✓	✓	Marion	✓	✓			✓	✓
Charlotte	✓				✓		Martin	✓				✓	✓
Citrus	✓	✓			✓		Miami-Dade	✓	✓			✓	✓
Clay	✓	✓			✓		Monroe	✓		No HMOs offered in this county.			
Collier	✓				✓		Nassau	✓	✓			✓	
Columbia	✓	✓			✓	✓	Okaloosa	✓				✓	
Desoto	✓				✓		Okeechobee	✓				✓	
Dixie	✓	✓			✓	✓	Orange	✓	✓			✓	
Duval	✓	✓			✓		Osceola	✓	✓			✓	
Escambia	✓				✓	✓	Palm Beach	✓	✓			✓	✓
Flagler	✓			✓	✓		Pasco	✓	✓			✓	
Franklin	✓				✓	✓	Pinellas	✓	✓			✓	
Gadsden	✓		✓		✓	✓	Polk	✓	✓			✓	
Gilchrist	✓	✓			✓	✓	Putnam	✓				✓	
Glades	✓				✓		Santa Rosa	✓				✓	✓
Gulf	✓				✓		Sarasota	✓	✓			✓	
Hamilton	✓	✓			✓	✓	Seminole	✓	✓			✓	
Hardee	✓				✓		St. Johns	✓	✓			✓	
Hendry	✓				✓	✓	St. Lucie	✓				✓	✓
Hernando	✓	✓			✓		Sumter	✓				✓	
Highlands	✓				✓		Suwannee	✓	✓			✓	✓
Hillsborough	✓	✓			✓		Taylor	✓				✓	
Holmes	✓				✓		Union	✓	✓			✓	✓
Indian River	✓				✓		Volusia	✓			✓	✓	
Jackson	✓				✓		Wakulla	✓		✓		✓	✓
Jefferson	✓		✓		✓	✓	Walton	✓				✓	
Lafayette	✓				✓	✓	Washington	✓				✓	
Lake	✓	✓			✓								

## RETIREE HEALTH INSURANCE PREMIUM RATE CHART

### IMPORTANT REMINDERS FOR ALL RETIREES:

- When you choose a plan, you **must** also enroll in Medicare Part B once you become eligible for Medicare (usually age 65 or due to a disability). Otherwise, you will pay the first 80% of your healthcare and prescription costs.
- When you become eligible for Medicare, please mail a **copy** of your Medicare card (with your People First ID written in the top right corner) to:
 

People First  
PO Box 6830  
Tallahassee, FL 32314
- Call (866) 663-4735 to deduct premiums from your monthly retirement pension check (FRS) or mail payment with coupon by the 10th prior to the effective date of coverage. For example, mail payment by January 10 for February coverage. Make your check payable to DSGI and mail to:
 

People First  
PO Box 863477  
Orlando, FL 32886-3477
- If you have automatic bill pay service, call your bank or credit union to change the premium payment amount to ensure your coverage continues.
- If you are moving or will be on extended travel, update your address information in People First.

### PPO Plan - Premiums effective June 1, 2009 through April 30, 2010

STANDARD PLANS:	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
State's PPO Plan (BlueCross & Caremark)	\$498.68	\$1,127.74	\$264.78	\$763.46	\$529.56
<b>HEALTH INVESTOR HEALTH PLANS:</b>					
(High Deductible Plans, No State Contributions)	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
State's PPO Plan (BlueCross & Caremark)	\$422.02	\$928.72	\$199.58	\$659.40	\$399.16

### PPO Plan - Premiums effective May 2010 for June 2010 coverage

STANDARD PLANS:	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
State's PPO Plan (BlueCross & Caremark)	\$523.62	\$1,184.14	\$278.02	\$801.64	\$556.04
<b>HEALTH INVESTOR HEALTH PLANS:</b>					
(High Deductible Plans, No State Contributions)	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
State's PPO Plan (BlueCross & Caremark)	\$446.96	\$985.11	\$209.56	\$656.52	\$419.12

<sup>1</sup>Medicare I is an individual plan for one person eligible for Medicare Parts A and B due to age or disability.

<sup>2</sup>Medicare II is a family plan for two or more people; at least one family member is eligible for Medicare Parts A and B.

<sup>3</sup>Medicare III is a family plan for only two people and both are eligible for Medicare Parts A and B.

## RETIREE HEALTH INSURANCE PREMIUM RATE CHART

### HMO Plans - Premiums effective December 1, 2009 for January 2010 coverage

STANDARD PLANS:	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
AvMed	\$498.68	\$1,127.74	\$287.39	\$815.01	\$574.80
Capital Health Plan	\$498.68	\$1,127.74	\$240.50*	\$902.81*	\$481.00*
Florida Health Care Plan	\$498.68	\$1,127.74	\$40.00*	\$635.89*	\$80.00*
United Healthcare	\$498.68	\$1,127.74	\$307.34	\$961.37	\$614.69
VISTA	\$498.68	\$1,127.74	\$299.56	\$1,099.51	\$599.14

  

HEALTH INVESTOR HEALTH PLANS: (High Deductible Plans, No State Contributions)	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
AvMed	\$422.02	\$928.72	\$287.39	\$795.44	\$574.80
Capital Health Plan	No HIHP	No HIHP	No HIHP	No HIHP	No HIHP
Florida Health Care Plan	\$422.02	\$928.72	\$40.00*	\$528.49*	\$80.00*
United Healthcare	\$422.02	\$928.72	\$209.60	\$655.66	\$419.22
VISTA	\$422.02	\$928.72	\$211.30	\$775.53	\$422.59

### HMO Plans - Premiums effective May 2010 for June 2010 coverage

STANDARD PLANS:	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
AvMed	\$523.62	\$1,184.14	See chart above. Rate change was made in December 2009 for January 2010 coverage.		
Capital Health Plan	\$523.62	\$1,184.14			
Florida Health Care Plan	\$523.62	\$1,184.14			
United Healthcare	\$523.62	\$1,184.14			
VISTA	\$523.62	\$1,184.14			

  

HEALTH INVESTOR HEALTH PLANS: (High Deductible Plans, No State Contributions)	Less than 65 Years of Age		65 Years of Age and Older (Medicare eligible)		
	Individual	Family	<sup>1</sup> Medicare 1	<sup>2</sup> Medicare 2	<sup>3</sup> Medicare 3
AvMed	\$446.96	\$985.11	See chart above. Rate change was made in December 2009 for January 2010 coverage.		
Capital Health Plan	No HIHP	No HIHP			
Florida Health Care Plan	\$446.96	\$985.11			
United Healthcare	\$446.96	\$985.11			
VISTA	\$446.96	\$985.11			

<sup>1</sup>Medicare I is an individual plan for one person eligible for Medicare Parts A and B due to age or disability.

<sup>2</sup>Medicare II is a family plan for two or more people; at least one family member is eligible for Medicare Parts A and B.

<sup>3</sup>Medicare III is a family plan for only two people and both are eligible for Medicare Parts A and B.

\* In addition to Medicare, for CHP and FHCP, you must enroll in their Medicare Advantage plan.

People First Service Center • P.O. Box 6830 • Tallahassee, FL 32314 • Tel: 866-663-4735 • Fax: 904-828-6092 • TTY: 866-221-0268

**Please return this completed form to the address or fax number above to continue or cancel your health and/or life insurance benefits.**

People First Employee ID: \_\_\_\_\_ Name: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

Day Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please check the appropriate box(es) to indicate your choice(s).**

Regular Retirement       Disability Retirement       Optional Retirement Plan       PEORP

Employment termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Part 1: Health Insurance Election**

I want to continue my current level of health insurance coverage as a retiree.

I want to make the following changes to my health insurance coverage as a retiree:

Change my coverage level to:

(01) Individual – Not entitled to Medicare / Not enrolled in Medicare

(09) Family - Not entitled to Medicare / Not enrolled in Medicare

**If you are eligible for Medicare, you may only select from the plans below:**

(23) Medicare I – An individual plan for one person eligible for Medicare Parts A and B due to age 65 or disability\*

(24) Medicare II – A family plan for more than two people; at least one family member is eligible for Medicare\*

(25) Medicare III – A family plan for only two people and both are eligible for Medicare\*

\*State Group Insurance pays claims secondary to Medicare.

I want to end my State Health Insurance Coverage.

**NOTE: If you end your coverage, you will not be eligible to re-enroll in the State Health Insurance Program.**

**Part 2: Life Insurance Election**

**I want to continue my Basic Life insurance coverage at one of the benefit levels below. I understand that these benefits and rates are subject to change:**

I understand that the amount of life insurance shall be \$10,000, the accidental death and dismemberment benefits (AD&D) shall not exceed \$10,000, and the monthly premiums shall be \$29.65.

I understand that the amount of life insurance shall be \$2,500, the accidental death and dismemberment benefits (AD&D) shall not exceed \$2,500, and the monthly premiums shall be \$7.41.

*(If I cease active employment due to total disability, the benefit would be based on my benefit amount at the time of the disability.)*

I do not want to continue my Basic Life insurance coverage under the State Group Life Insurance Plan as a retiree and request that the coverage be terminated.

**NOTE: If you end your coverage, you will not be eligible to re-enroll in the State Life Insurance Program.**

**Part 3: Method of Premium Payment**

I will submit premium payments to People First by the tenth of the month before each month of coverage.

I have elected to continue benefits coverage as indicated above and authorize People First to have the appropriate deductions taken from my retirement warrant from the Division of Retirement.

Retiree Signature \_\_\_\_\_

Date \_\_\_\_\_

- The State Group Insurance Plan ("Plan") cannot use or disclose your health information (or the health information of your children or other people on whose behalf you can act) for certain purposes without your authorization. This form is intended to meet the authorization requirement.
- You must respond to each section and sign and date this form for the authorization to be valid.
- To authorize the use and/or disclosure of any records or documents the Plan may have that were taken by a mental health professional, including a psychiatrist or a psychologist, during a counseling session, you must complete a form for the counseling session records or documents and a separate form for other health information.
- Under HIPAA, you have the right to authorize the release of all information or to describe and limit the information to be released.

**Section A: Health Information to be Used or Disclosed.**

- Describe in a specific and meaningful way the information to be used or disclosed. Example descriptions include medical records relating to your appendectomy, your laboratory results, and medical records from [date] to [date], or the results of the MRI performed on you in July 1998.

**Section B: Purpose(s) for which Information will be Used or Disclosed.**

- Describe each purpose for which the information will be used or released. If you initiate the authorization and do not wish to provide a statement of purposes, you may select "at my request."

**Section C: Expiration.**

- Specify when this authorization will expire. For example, you may state a specific date, a specific period of time following the date you signed this Authorization Form, or the resolution of the dispute for which you've requested assistance.

**Signature Line.**

- If you are authorizing the release of somebody else's health information, then you must describe your authority to act for the individual.
- Complete and sign this form and send it to:

People First Service Center  
PO Box 6830  
Tallahassee, FL 32314

Or

FAX: (904) 828-6092

- For help, call (866) 663-4735 or TTY (866) 221-0268, Monday through Friday, from 8:30 a.m. to 5:30 p.m. Eastern Time.

# Authorization to Use and/or Disclose Personal Health Information

## I. Individual (Name and information of person whose personal health information is being disclosed.)

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
People First ID Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Complete Mailing Address

\_\_\_\_\_  
Area Code & Telephone Number

## II. Authorization and Purpose:

I hereby authorize People First Service Center, on behalf of State Group Insurance Plan ("Plan"), to disclose the health information as described in Sections A-C below. The health information is to be disclosed to or delivered to (as requested):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Complete Mailing Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Area Code & Telephone Number

### Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one of the following boxes.

- All of my past, present or future health claims and/or medical records.
- All of my health information relating to Claim Number \_\_\_\_\_.
- Information regarding prescription drug coverage.
- My health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).
- My health information regarding treatment for alcohol and/or substance abuse.
- My health information regarding behavioral health services, counseling notes or psychiatric or psychological care provided by \_\_\_\_\_ (Name of individual provider or facility).
- Other (please specify) \_\_\_\_\_

### Section B: Purpose(s) for Which Information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

- To facilitate the resolution of a claim dispute
- As part of my application for leave of under the Family and Medical Leave Act (FMLA) or state family leave laws.
- For a disability coverage determination
- At my request
- Other (please specify) \_\_\_\_\_

# Authorization to Use and/or Disclose Personal Health Information

## Section C: Expiration of Authorization.

Specify when the Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

- On the following date: \_\_\_\_\_
- Upon the passage of the following amount of time: \_\_\_\_\_
- Upon disenrollment from my State-sponsored health plan.
- Upon my return from FMLA leave.
- Other (please specify) \_\_\_\_\_

## III. Your rights:

- You can revoke this Authorization at any time by submitting a written revocation to the address below.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information has been disclosed pursuant to this Authorization, neither the Plan nor People First has control over the use and distribution by recipient.
- The Plan may not condition Treatment, Payment, Enrollment or Eligibility for benefits on whether I sign the Authorization.
- If this Authorization is requested so the Plan can make an eligibility or enrollment determination, then the Individual may be ineligible for enrollment or benefits if you fail to sign this form. This applies to persons not yet enrolled in the Plan.
- We will provide you a copy of your signed Authorization Form upon request.

## IV. Your Authorization:

This form must be signed by the Individual, parent of minor child or the personal representative. The personal representative includes persons with power of attorney, legal guardian, executor or administrator of an estate.

\_\_\_\_\_  
Signature of Individual or Personal Representative                      Date

If you are signing as a personal representative, attach a copy of your legal documents.

\_\_\_\_\_  
Personal Representative's Name (Print)                                      Relationship to Individual

\_\_\_\_\_  
Personal Representative's Address                                      City                                      State                                      Zip

\_\_\_\_\_  
Personal Representative's Telephone Number

Keep a copy for your records and send the completed form to the following address or fax number:

People First Service Center  
PO Box 6830  
Tallahassee, FL 32314  
(904) 828-6022 Fax