RETIREE / SURVIVING SPOUSE HEALTH INSURANCE
2008 ENROLLMENT FORM
(Please Print)

Select your Enrollment Type: ☐ Open Enrollment ☐ Qualifying Status Change

Note: If checked, you must also complete and submit Qualifying Status Change form.

SSN: ☐☐☐☐☐☐☐☐☐ **EEID:** 0 0 ☐☐☐☐☐☐

Name: _____ **Agency Name:** _____

Complete Mailing Address: _____

Work Phone: ( ) _____ **Home Phone:** ( ) _____ **Sex (M/F):** ___ **Birth Date:** ___/___/___

PART 1: HEALTH INSURANCE - Please check (✓) your choice(s).

☐ **I WISH TO CHANGE THE FOLLOWING PLAN TYPE:**

- ☐ State PPO Plan
- ☐ State **HIHP** PPO Plan
- ☐ Health Maintenance Organization (HMO) Plan
- ☐ **HIHP** Health Maintenance Organization (HMO) Plan

HMO PLAN NAME: _____

NOTE: You must reside in a county the HMO serves.

☐ **I WISH TO TERMINATE MY STATE HEALTH INSURANCE**

NOTE: A retiree who terminates coverage will not be eligible to re-enroll in the Health Insurance Program unless re-employed by the State.

☐ **I AM A SURVIVING SPOUSE AND I HAVE REMARRIED.** Date of Marriage: ☐☐/☐☐/☐☐☐☐

☐ **I WISH TO CHANGE TO THE FOLLOWING HEALTH PLAN COVERAGE:**

- ☐ (01) Individual - Not entitled to Medicare / Not enrolled in Medicare
- ☐ (09) Family - Not entitled to Medicare / Not enrolled in Medicare
- ☐ (23) Medicare I - Individual enrolled in Medicare Parts A & B
- ☐ (24) Medicare II - One or more members Medicare-eligible, One ore more members not Medicare-eligible
- ☐ (25) Medicare III - Both family members Medicare-eligible

PART 2: ADD / DROP DEPENDENTS - Please Print

You may: **ADD** eligible dependents not currently covered and/or **DROP** ineligible dependents.

***RELATIONSHIP:** Put the number that is next to the relationship, an example is Spouse-1 then you would put the 1 in the "Rel." column below.

Spouse - 1, Child - 2, Legal Guardianship - 3, Grandchild - 4, Legally Adopted Child - 5, Foster Child - 6, Step Child -7, Unborn Child - 8

Add	Drop	Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Sex M/F	*Rel.
☐	☐			/ /		
☐	☐			/ /		
☐	☐			/ /		
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PART 3: EMPLOYEE CERTIFICATION

I authorize the State of Florida to deduct the proper premiums for the selected coverage from my retirement check. If my retirement check is not sufficient to pay the premiums, I will submit the amount due by personal check or money order by the 10th day of each month for the next month's coverage (For example, the premium for the month of February's coverage is due at the Service Center by January 10th.).

Employee Signature: _____ **Date:** _____

Member SSN - for Surviving Spouse only ☐☐☐☐☐☐☐☐☐

COMPLETION OF THIS FORM MEANS THAT YOU HAVE READ AND AGREE TO COMPLY WITH THE FOLLOWING:

- Review your current benefits and the available plans and options.
- Select the benefit options **most suited** to your personal needs.
- Submit supporting documentation, if required, for dependent enrollment to the People First Service Center (refer to address below).
- **You must drop all of your ineligible dependents**. If you are dropping **all** of your dependents, you must change your coverage to individual. As a retiree, if you **terminate** your health insurance **you will not be able to re-enroll again unless you are re-employed by the State.**
- Health plan participants should receive plan information and their I.D. cards in a timely manner. If you do not receive your I.D. card in a timely manner, call the health plan you selected.
- You may obtain any needed forms via the People First website at https://peoplefirst.myflorida.com or the People First Service Center at 1-866-ONE-HRFL (1-866-663-4735).
- If you are retired and experience a qualifying status change, as defined by the Internal Revenue Code and/or the Florida Administrative Code, you may be eligible to change your current benefit elections. If you do not make any changes during the qualifying status change period, your elections will remain in effect for the remainder of the calendar year.
- The **effective date** will coincide with your date of retirement. You must also submit corresponding effective month's premium payment (personal check, if applicable) to the following address:

  People First Service Center

  Post Office Box 863477

  Orlando, FL 32886-3477

- Please **MAIL** or **FAX** your completed and signed enrollment form and Qualifying Status Change form, if applicable, to the People First Service Center at the address or fax number noted below.

  People First Service Center

  Post Office Box 6830

  Tallahassee, FL 32314

  FAX: (904) 828-6092