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-05
08/13

# Flexible Spending Account Options When Employment Ends 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 Participant Information - REQUIRED FIELDS*

People First ID* (0 + 7 digits)

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 Payroll Information

Name of Employer (Department, Agency, University, etc.): _____

I am paid: ☐ Biweekly ☐ Monthly

Termination Date: Month Day Year

## SECTION C Employee Instructions - Current Status of Your Medical Reimbursement Account (MRA)

To complete each line in Section E, follow these steps:

| | |
|---|---|
| 1. Current MRA Balance | In People First, click FSA Information in the My Quick Links section on the left. See the Available Amount in your account snapshot. |
| 2. Annual Elected Amount | See the Total Annual Election Amount in your account snapshot. |
| 3. Current Year-to-Date Contributions | Go to Account balance in the menu bar at the top of the screen. See dollar amount[1] from Year-to-Date Paid In. |
| 4. Remaining Regular Payroll Contributions, if any | Project dollar amount based on your termination date |
| 5. Total Year-to-Date Contributions upon Final Regular Payroll | Add lines 3 and 4 |
| 6. Balance Due to meet Annual Elected Amount | Subtract line 5 from 2 |

[1]This amount is accurate only if all claims have been processed.

# Flexible Spending Account Options When Employment Ends Form

People First ID*

| 0 | | | | | | | |
|---|---|---|---|---|---|---|---|

## SECTION D Employee Instructions - Participation Options

To complete each line in Section F, follow these steps:

1. **Select your Participation Option:**
   - To continue, check Box ❶ in Section F, then follow step 2 in this section.
   - To terminate, check Box ❷ in Section F, sign, date and mail your completed form to the People First Service Center address below.
2. **Select your Payment Option:**
   - To check your annual or sick leave accrual balance (in hours) in People First, click Employee Information > Time and Payroll > Leave Balance Overview.
3. **If you choose option:** **Send your form to:**

   A or B ..... Your agency Human Resource office for final leave processing
   C ..... The People First Service Center
   D ..... The People First Service Center to confirm your monthly contribution amount, including the 2% administrative fee

   If you choose an option that requires payment, make your check or money order payable to the Pretax Benefits Trust Fund, write your People First ID number on your payment and "MRA balance due" on the memo line, and mail to People First Service Center, PO Box 863477, Orlando, FL 32886-3477
4. Mail or fax your completed and signed election form to People First Service Center, PO Box 6830, Tallahassee, FL 32314 or fax to (800) 422-3128.
5. Keep a copy of your completed form for your records.

## SECTION E Current Status of Your MRA - Complete this section only if you are continuing participation (see instructions in Section C). If not, check box❷ in Section F.

1) Current MRA Balance as of: Month Day Year is $ . 
2) Annual Elected Amount: $ . 0 0
3) Current Year-to-Date Contributions - last deposit on: Month Day Year is $ .
4) Remaining Regular Payroll Contributions (if any): $ .
5) Total Plan Year-to-Date Contributions upon Final Regular Payroll - add lines 3 and 4: $ .
6) Balance due to meet Annual Elected Amount - subtract line 5 from line 2: $ .

# Flexible Spending Account Options When Employment Ends Form

People First ID*
0 | | | | | | | |

## SECTION F Participation Options

☐ ❶ **I elect to continue participation** for the remainder of the current Plan Year. I will make my Medical Reimbursement Account premium contributions by the method checked below. I understand that if I do not honor my payment agreement, my participation in the Plan will be terminated and I will not be eligible to file claims for expenses incurred after my period of participation. I understand that it is my sole responsibility to make payments by personal check or money order by the due date, payable to the Pretax Benefits Trust Fund. I will not receive any notice of payment due or of non-payment. I will not be eligible to resume participation if I am rehired by the state during the current Plan Year.

☐ A. **Full payment of balance due** (from line 6) $ | | | | • | | made on pretax basis from my annual or sick leave payout. If these funds are not sufficient to pay the Balance Due, I authorize payment of the full amount available, up to the amount listed in this option, and I will pay the difference by personal check or money order within **45 calendar days** of my leave payout processing date.

☐ B. **Partial payment** of $ | | | | • | | made on a pretax basis from my annual or sick leave payout. The Remaining Balance of $ | | | | • | | I will pay by personal check or money order within **45 calendar days** of the signature date on this form, or the processing date of my leave payout, whichever occurs first. If leave funds are not sufficient to cover the designated partial payment, I authorize payment of the full amount available, up to the partial payment amount listed in this option. I will meet my Remaining Balance Payment by personal check or money order accordingly.

☐ C. **Full payment** of $ | | | | • | | paid by personal check or money order within **45 calendar days** of the signature date on this form.

☐ D. **Monthly payments** by personal check or money order due on the **first day of each month** as follows:

Number of Payments | | of $ | | | | | • | | beginning | | | | | | | | |
Month Day Year

Payments are due on the first day of each month and should include a 2% administrative fee. Please call the People First Service Center at (866) 663-4735 if you need help.

☐ ❷ **I elect to terminate my participation in the plan.** I understand that any claims for expenses incurred after my period of participation will not be eligible for reimbursement and that If I am rehired by the State during the current Plan Year, I will not be eligible to resume participation.

Participant Signature* _____ Date* _____

Agency HR Signature* _____ Date* _____

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

**Mail payments to People First Service Center • PO Box 863477 • Orlando, FL 32886-3477**

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.