SGI-12
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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**_____

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Surviving Spouse Election Form

People First
STATE OF FLORIDA HR

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 Surviving Spouse 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 State Group Health Insurance - Please check (✓) your choice(s).

☐ I want to **continue** my current insurance plan at the family coverage level.

☐ I want to **change** my family health insurance coverage to individual coverage. (You must have an appropriate Qualifying Status Change (QSC) event to go back to family coverage; otherwise, I can only make a change during Open Enrollment.

☐ I want to **end** my state health insurance coverage. If I end my health coverage, I will not be allowed to join the plan at a later date.

If you and/or your dependent(s) are eligible for Medicare[1], you may only select from these options:

☐ Medicare I - An individual plan for you if you are eligible for Medicare Parts A and B due to age 65 or disability.

☐ Medicare II - A family plan for two or more people, if at least one family member is eligible for Medicare Parts A and B due to age 65 or disability.

☐ Medicare III - A family plan for only two people and both are eligible for Medicare Parts A and B due to age 65 or disability.

[1]State group health insurance plans pay claims secondary to Medicare, even if you do not enroll in Medicare. You must send a copy of any Medicare cards to People First at the address or fax number on page 2 of this form.

Surviving Spouse Election Form

People First ID*

0							

SECTION C 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.

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

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

SECTION D Method of Premium Payment

To complete your enrollment, you must submit the required premium for the first month of coverage to People First. You must submit a check, money order, or cashier's check to the payment address at the bottom of this page. All payments are due a month in advance for the next month's coverage.

After you pay your first month's premium, you have two payment options (check one):

☐ I will submit premium payments to People First by the 10th day of each month for the following month's coverage.

☐ I authorize the State of Florida to deduct from my FRS monthly pension payment the amount necessary to pay the premiums for the coverage I have selected.

SECTION E Surviving Spouse and Dependent 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 enrollment in the State Health Insurance Program will be complete only if People First receives a copy of the death certificate and my first month's premium. If checked above as my preferred payment method, I authorize the State of Florida to deduct from my FRS monthly pension payment the amount necessary to pay the premium for the coverage I have selected. If I do not receive a monthly retirement benefit or if it is not sufficient to pay the premium, I will submit the amount due by personal check, money order or cashier's check by the 10th day of each month for the following month's coverage. I understand that my coverage starts the first day of the month after my spouse's coverage ends. I understand that if I remarry, I am no longer eligible for coverage; however, if I provide my marriage certificate within 60 days of remarrying, I may continue coverage for up to 18 months under COBRA. I understand that I may cancel my insurance coverage at any time but will not be allowed to join at a later date. All other changes can only be made if I have a Qualifying Status Change event or during Open Enrollment. I must request changes within 60 calendar days of the Qualifying Status Change event.

Surviving Spouse Signature* _____ **Date*** _____

Mail this completed form with a copy of the death certificate 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.